# JOURNAL

*of the*

# AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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VOLUME 50, NUMBER 11

NOVEMBER, 1960

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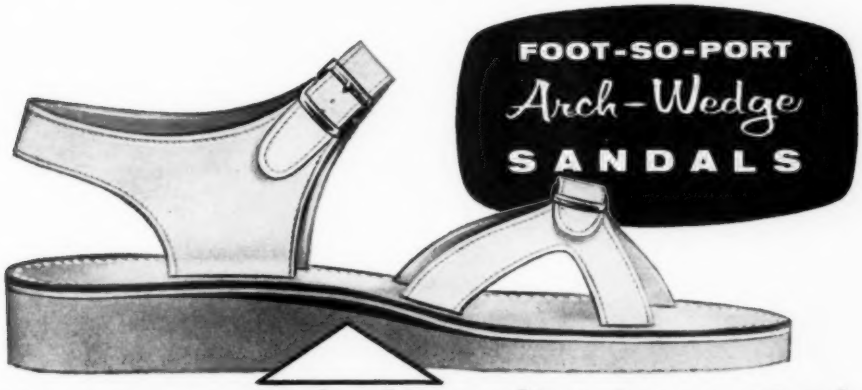


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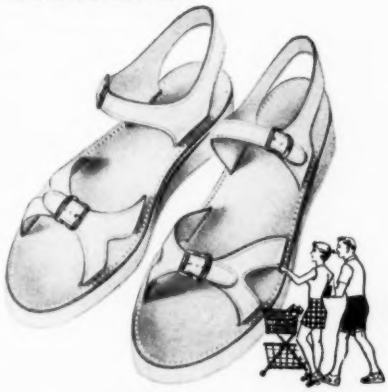

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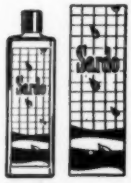


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3. Prentice, H. and Brezak, S.: J. Amer. Podiatry Assn., May 1958.

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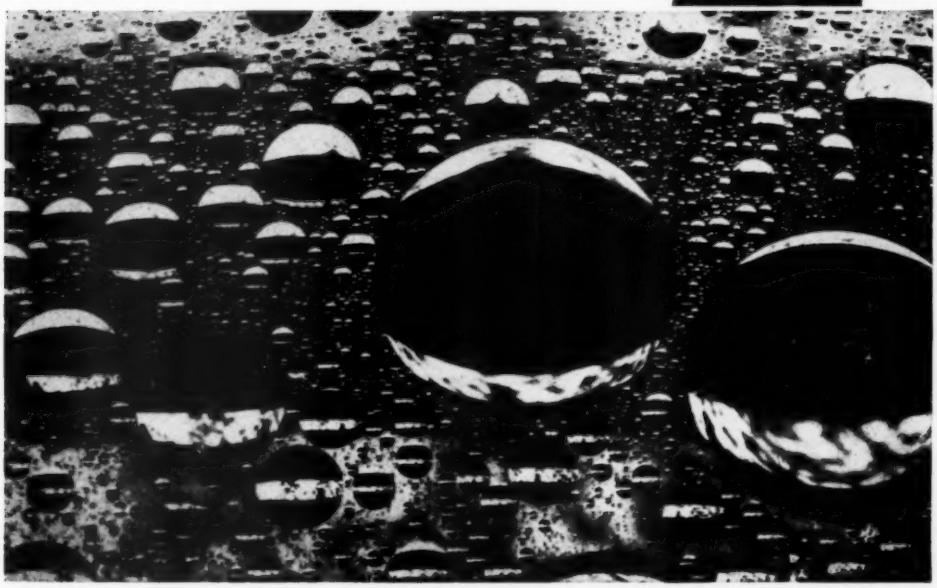

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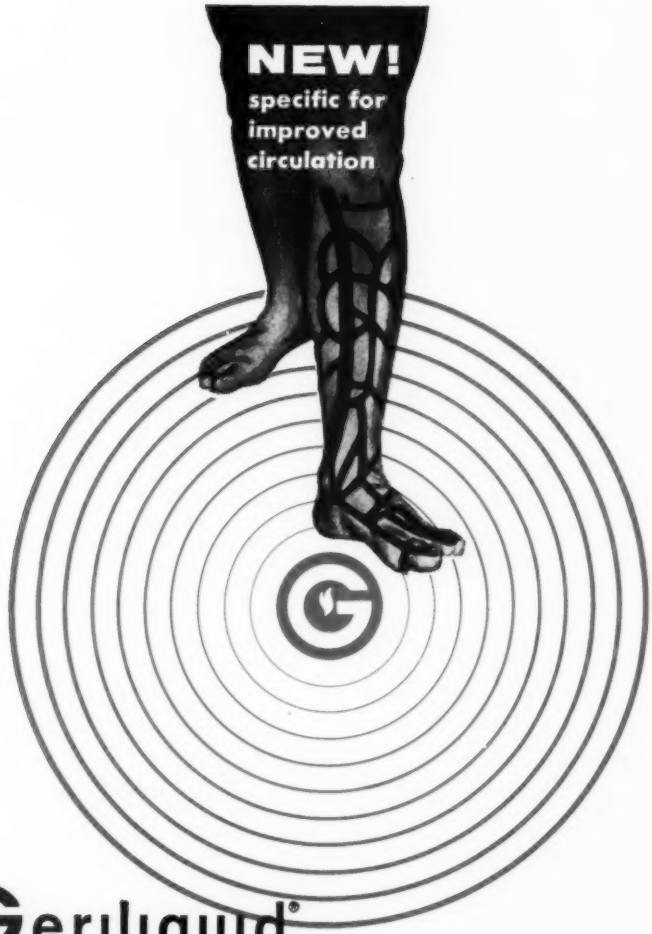


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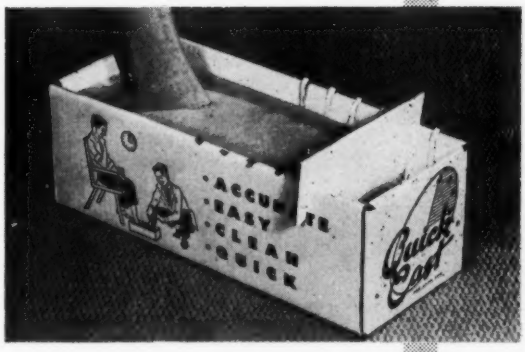


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| Oklahoma Chiropody Association | Jeane L. Johnson, 510 W. Broadway, Enid, Okla.<br>H. R. Johnson, 401 N. Beard St., Shawnee, Okla. |
| Oregon Podiatry Association, Inc. | George McCauley, 4126 N. E. Broadway, Portland, Ore.<br>William V. Wheeler, 405 High St., N. E., Salem, Ore. |
| Pennsylvania, Chiropody Society of | Joseph D. Fletcher, 520 Temple Bldg., New Castle, Pa.<br>Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa. |
| Rhode Island Podiatry Society | Edward L. Hochman, 452 Main St., Pawtucket, R. I.<br>Leonard H. Lerner, 1045 Warwick Ave., Warwick, R. I. |
| South Carolina Podiatry Association | James D. Hill, 122 W. Whitner St., Anderson, S. C.<br>H. A. McAninch, 169 Hall St., Spartanburg, S. C. |
| South Dakota Association of Chiropodists | M. D. Scofield, 120 W. 11th St., Sioux Falls, S. Dak. |
| Tennessee Chiropody Association | Richard J. Koch, 1203 Warner Bldg., Nashville, Tenn.<br>Ronald E. Fields, 524 Bennie Dillon Bldg., Nashville, Tenn. |
| Texas, Chiropody Society of | Ben Smith, Jr., 737 Wilson Bldg., Dallas, Tex.<br>J. Gordon Russell, Goodhue Bldg., Beaumont, Tex. |
| Utah State Association of Chiropodists | Ralph Self, Boston Bldg., Salt Lake City, Utah<br>Howard Jasperson, Judge Bldg., Salt Lake City, Utah |
| Vermont Chiropody Association | Gray S. Clark, 128 Merchants Row, Rutland, Vt.<br>Regis P. Nolin, 14 Clarke St., Burlington, Vt. |
| Virginia, Podiatry Society of | Herman Chapel, New Monroe Bldg., Norfolk, Va.<br>I. Leonard Kaplan, 718 Court St., Portsmouth, Va. |
| Washington State Podiatry Association | R. A. Watters, 1306 N. Eye St., Tacoma, Wash.<br>Kurt Blau, 501 Medical Arts Bldg., Tacoma 2, Wash. |
| West Virginia, Chiropody Society of | Malcolm P. Iams, 716 Juliana St., Parkersburg, W. Va.<br>G. A. Taylor, 1st Huntington Natl. Bank Bldg., Huntington, W. Va. |
| Wisconsin Society of Chiropodists | Eugene V. Hurtienne, 2705 North 8th St., Sheboygan, Wisc.<br>Michel M. Addis, Med. Arts Bldg., 945 N. 12 St., Milwaukee 3, Wis. |
| Wyoming Podiatry Society | E. O. King, Odd Fellows Bldg., Casper, Wyo.<br>Duane NeuSchultz, 2201 West A, Torrington, Wyo. |

## Affiliated Organizations

*Women's Auxiliary A.P.A. (N.A.C.)*—Mrs. Cleotha Parham, 5328 E. 26th St., Tulsa, Okla.
*Military Association of Podiatrists*—Lt. John L. Charlton, Jr., D.S.C., Podiatry Clinic, Walter Reed Army Hospital, Washington, D. C.
*American College of Foot Surgeons*—J. M. Kohl, 3959 No. Lincoln Ave., Chicago 13, Ill.
*American Society of Chiropodical Roentgenology*—Joseph L. Starr, 1115 Main St., Bridgeport, Connecticut
*Chiropody Bibliographical Research Society*—S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa
*American College of Foot Orthopedists*—L. B. Thompson, 5613 7th Ave., Kenosha, Wisc.
*American Association of Hospital Podiatrists*—H. Charles Lilienfeld, 101 W. 57th St., New York, N. Y.
*American Podiatry Students Association*—Bruce Wood, 206 Eureka St, San Francisco, Calif.
*American Board of Chiropodical Dermatology*—Joy E. Adams, Florida National Bank Bldg., St. Petersburg, Fla.

## Related

*Federation of Chiropody-Podiatry Boards*—L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.
*American Association of Colleges of Chiropody*—Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.
*National Board of Chiropody Examiners*—Pierce B. Nelson, 1770 Eddy St., San Francisco, Cal.
*American Academy of Chiropodists*—Robert Smith, 77 James St. North, Hamilton, Ontario 10, Canada.
*Academy of Podiatry*—Louis Lewy, 285 Madison Ave., New York, N. Y.
*American Podiatry Council*—L. J. Friedman, 1186 Broadway, New York, N. Y.
*Fellows Pedic Research Society*—Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.
*American Foot Health Foundation*—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

# ACCREDITED COLLEGES

**California Podiatry College**
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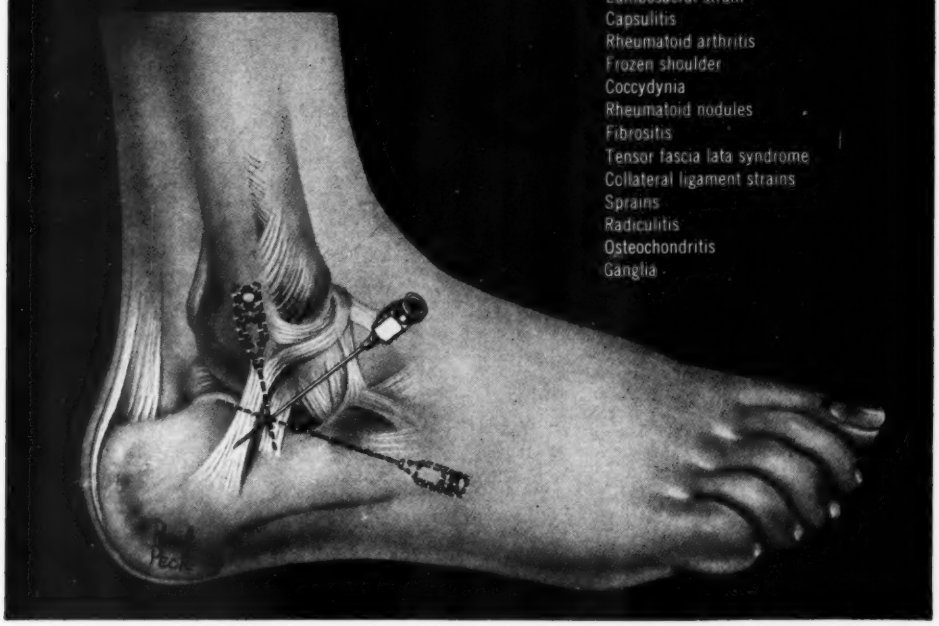

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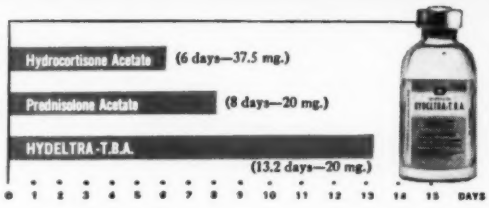
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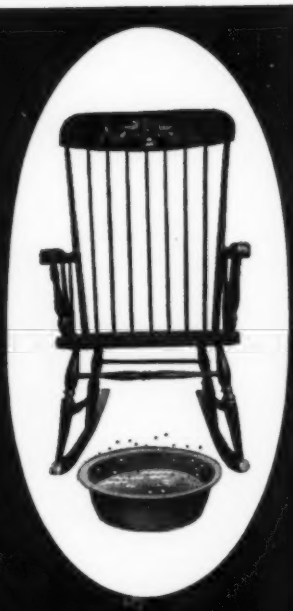

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—Walsh, W. R.: U. S. Armed Forces M. J. 4:563,1953

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## STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

**Alabama**

The Alabama Medical Board of Examiners. **Board Secretary:**

**Arizona**

The Arizona State Board of Chiropody Examiners. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Ariz.

**Arkansas**

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

**California**

The California Chiropody Examination Committee. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento, Calif.

**Colorado**

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Heibig, 327 Logan St., Denver, Colo.

**Connecticut**

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

**Delaware**

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

**District of Columbia**

The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually January 17, 18, 1961, and July. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

**Florida**

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

**Georgia**

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

**Idaho**

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

**Illinois**

The Illinois Chiropody Examining Committee will meet for reciprocity and examination in June 1961 at 160 No. LaSalle St., Chicago, Ill. **Superintendent of Registration:** Fredric B. Selke, Room 109, State House, Springfield, Ill.

**Indiana**

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

**Iowa**

The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

**Kansas**

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

**Kentucky**

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville, Ky.

**Louisiana**

Louisiana State Board of Medical Examiners will meet for examination Dec. 8-10, 1960, at Louisiana State University Medical School. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

**Maine**

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

**Maryland**

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

**Massachusetts**

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

**Michigan**

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

**Minnesota**

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

**Mississippi**

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

**Missouri**

The Missouri State Board of Chiropody. **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

**Montana**

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

**Nebraska**

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

**Nevada**

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

**New Hampshire**

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

**New Jersey**

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

**New Mexico**

The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

**New York**

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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—Cooper, W. M.: Am. J. Surg. 65:475, 1948.

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## STATE BOARD *(Cont.)*

**North Carolina**

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

**North Dakota**

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

**Ohio**

The Ohio State Medical Board will meet for examination Dec. 12, 1960, at Columbus, Ohio. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

**Oklahoma**

The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

**Oregon**

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

**Pennsylvania**

Pennsylvania State Board of Chiropody Examiners will meet for examination in July, 1961, at the Education Bldg., Harrisburg, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

**Rhode Island**

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

**South Carolina**

The South Carolina Board of Chiropody Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

**South Dakota**

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

**Tennessee**

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

**Texas**

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

**Utah**

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

**Vermont**

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

**Virginia**

Virginia Board of Medical Examiners. **Board Secretary:** Kenneth D. Graves, M.D., 631 First St., S.W., Roanoke, Va.

**Washington**

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

**West Virginia**

Medical Licensing Board of West Virginia will meet for examination January 9-10, 1961, at 1800 E. Washington St., Charleston, W. Va. **Board Secretary:** N. H. Dyer, 1800 E. Washington St., Charleston, W. Va.

**Wisconsin**

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

**Wyoming**

The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.


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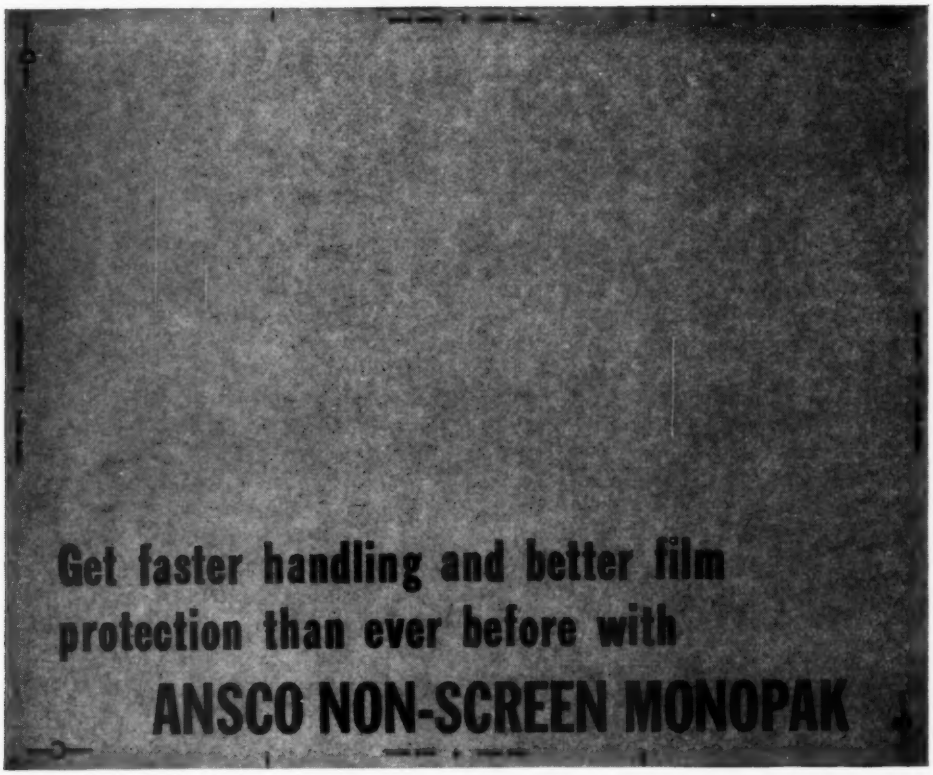


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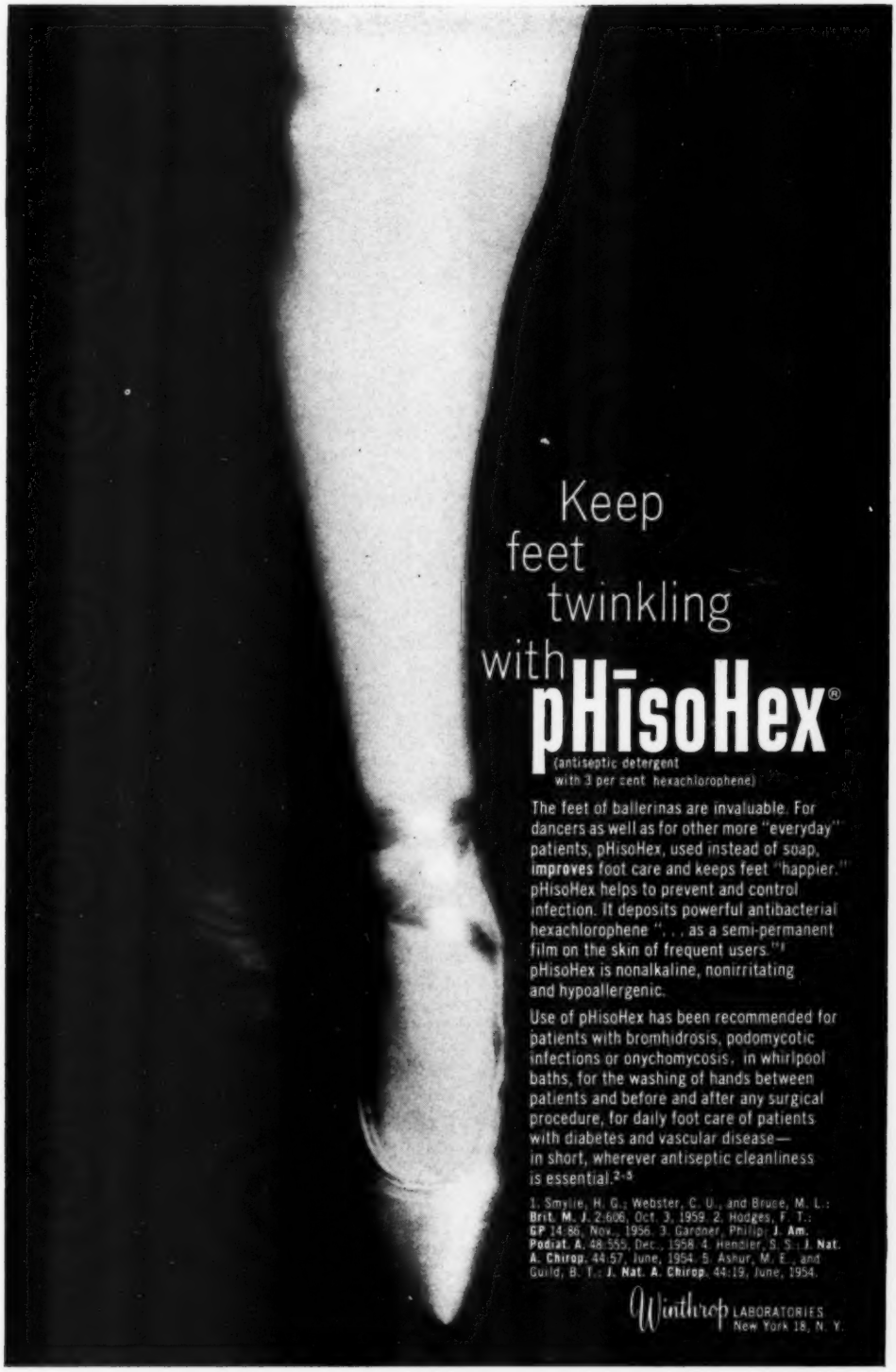
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1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: Brit. M. J. 2:606, Oct. 3, 1959. 2. Hodges, F. T.: GP 14:86, Nov., 1956. 3. Gardner, Philip: J. Am. Podiat. A. 48:555, Dec., 1958. 4. Hendler, S. S.: J. Nat. A. Chirop. 44:57, June, 1954. 5. Ashur, M. E., and Guild, B. T.: J. Nat. A. Chirop. 44:19, June, 1954.
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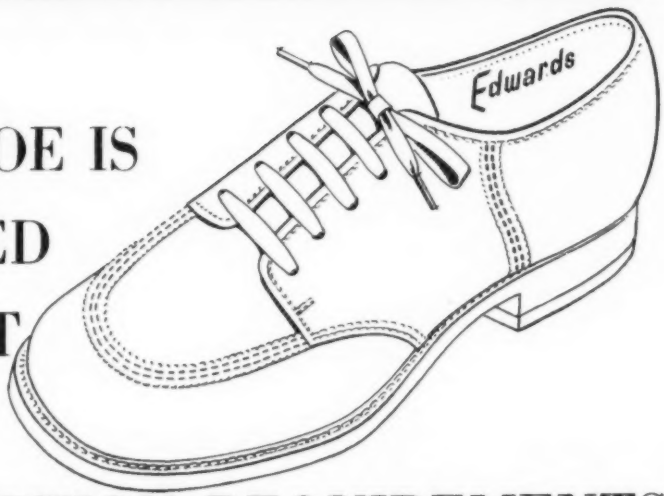


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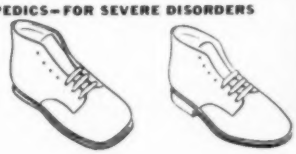

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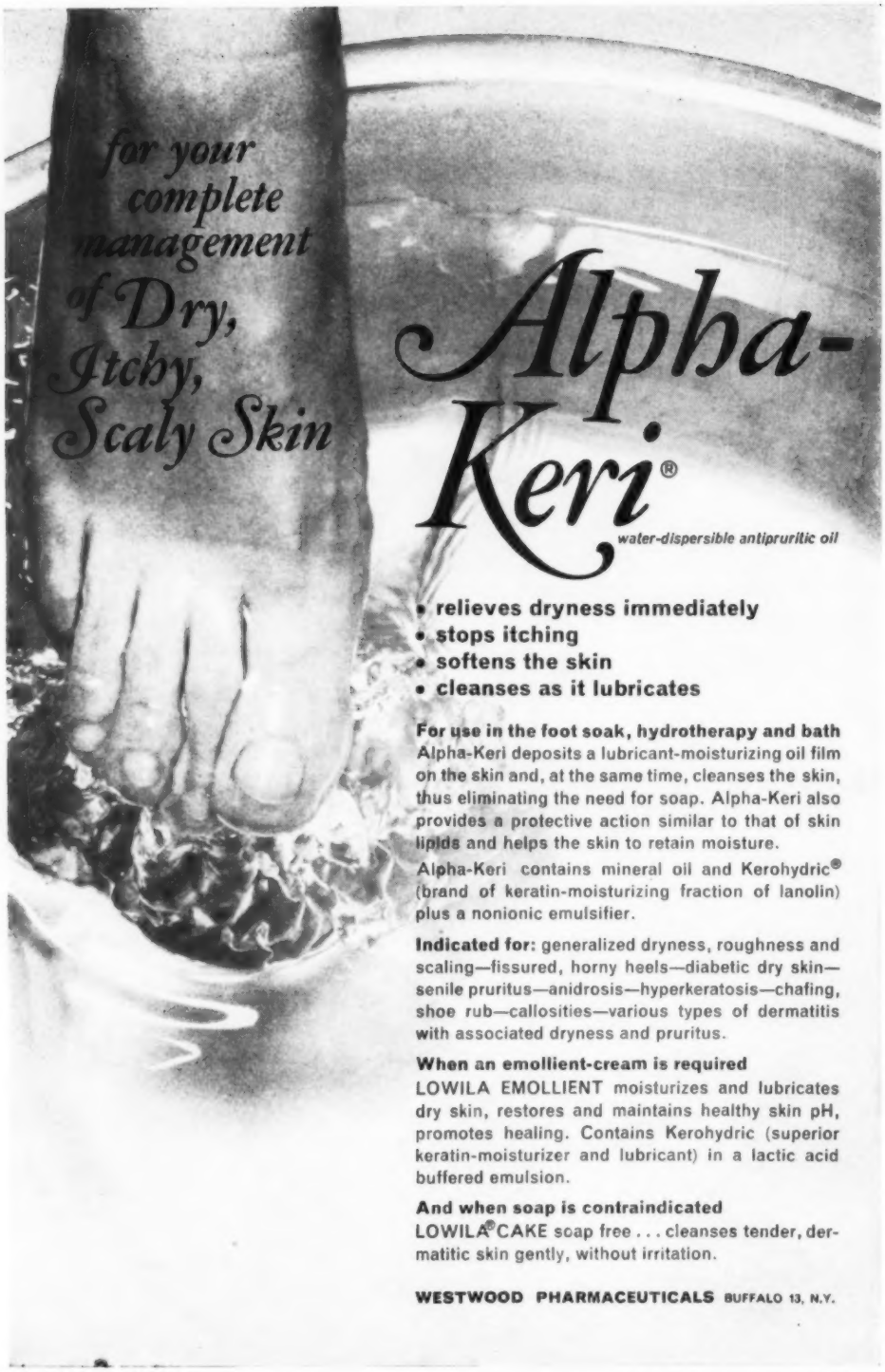
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# TOTAL CONTACT RESTORATION PROSTHESIS FOR PARTIAL FOOT AMPUTATIONS*

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In medical literature there are numerous references to substitution parts for amputated portions of the body. Throughout these publications there are only a few references to partial foot amputations, such as the statement by Daniel.[1] "After long experience and extensive investigation, it is seldom found that an artificial substitute can be worn after these partial foot amputations with any degree of comfort or satisfaction. Furthermore, the records of these cases show that over fifty per cent, sooner or later, submit to re-amputation. Often it is after losing several years of time, with the attendant financial expense of securing one foot after another, and after much suffering and many disappointments, that re-amputation is found necessary."

Since World War II much medical research has been directed toward the development of functional and cosmetic substitution parts for amputated portions of the body. During this extensive prosthetic development, no improved method over what was available before World War II has been made for the substitution of a partially amputated foot, although every other type of prosthetic has been improved upon.

The situation regarding prostheses for partial foot amputations can best be summed up in the statement by one prosthetic authority, Thomas,[2] who wrote, "The strain on any artificial appliance for partial foot or ankle joint amputation is severe and presents a formidable problem to the prosthesis maker. It is very difficult to make an appliance that is strong enough to withstand the strain to which it is subjected without making it so bulky as to be prohibitive from an aesthetic standpoint. Amputees, as a result, expect a great deal more from these foot appliances than it is possible for the limb maker to give them, therefore they are rarely satisfied with them. As a result, some of the most prominent limb makers in this country, rather than have dissatisfied customers, refuse to make these foot appliances at all."

Low level amputations of the extremities have become more common due to the use of antibiotics, recent research in vascular surgery and improved surgical techniques. The incidence of high level ampu-

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tations has been greatly reduced, resulting in many cases of amputations of the most distal portion of the affected extremity. With the increase of partial amputations of the foot, the need for rehabilitating these patients with an adequate functional prosthesis has become increasingly imperative. This study was instituted to develop a functional and restorative prosthesis for the partially amputated foot, regardless of the shape or level of the stump.

The most common substitution for partial amputations of the foot in use today is a filler in the shoe. The filler in no way restores the amputated portion of the foot, since it merely fills the shoe and assumes the function of the shoe. The shoe and the filler then act as one unit and rub on the end of the stump, causing pressure and sometimes ulceration on the distal end of the stump. Eventually the toe of the shoe points upward and becomes distorted and makes the amputee and the people with whom he associates aware of his deformity.

In some instances, a technique is utilized where a steel arch support with a toe extension, and a high laced anklet is laced around the stump and attached to the heel of the arch support. This is an improved method over that of the filler since it is somewhat attached to the extremity and to a limited degree, functions as part of the extremity. There are many disadvantages to this method. It is bulky and heavy, because of the materials used. It has poor conformity to the stump, and because of its weight, it is constantly pulling away at the heel. Its bulkiness necessitates a special shoe to be constructed. Constant repair is needed because it is essentially a rigid support and weight is being transferred from the heel to its forepart which concentrates pressure on the fulcrum of the appliance. This concentration causes a cracking or bending of steel which necessitates frequent replacement. The patient is never completely satisfied with this prosthesis. The most that can be hoped to be accomplished is that the patient will learn to live with it. Consequently, fifty per cent of these amputees submit to a higher level amputation and have a prosthesis with a full foot constructed.

### Purpose

This study was designed to create a prosthesis which more adequately restores the amputated portion of the foot and returns the greater part of the foot's functional ability. The purpose of the prosthesis is to establish a weight-bearing area similar to that of the normal foot, so that the trauma of weight bearing will not be concentrated on just the resultant stump. It is important the amputee be able to utilize the restoration in the dynamic phases of gait, as well as in the static position of standing.

### Materials and Methods

The materials and techniques that were utilized to construct this foot restoration prosthesis necessitated a complete departure from any previously employed method of constructing partial foot prosthesis. This produced a flexible, light weight, total contact restoration prosthesis that accurately conformed to the remaining portion of the foot and the inside dimensions of the shoe.

### Examination

The stump is carefully examined for areas of scarring, since allowances will have to be made for these areas in the construction of the prosthesis. Areas of excessive weight bearing are also noted. In a Lisfranc's amputation, the patient usually develops excessive callous formation under the cuboid. In patients where prostheses were not fitted early, there is plantar flexion of the stump with a contraction of the tendo-achilles, resulting in a postural shortage of the unamputated extremity. Some type of accommodation is necessary for these inequalities in leg length.

The patient's gait is closely examined since the old amputee will abduct the amputated foot while walking to create a wider weight-bearing surface. Allowances will have to be made for this abduction of the remaining portion of the foot.

It is important that the appearance of the shoe is acceptable to the patient. The psychological rehabilitation is as important as his physical rehabilitation. The patient is advised to purchase a shoe which fits well on his unamputated foot, has a leather sole, rubber heel and a high vamp. This eliminates a loafer and a low boy shoe, but the patient will usually be able to wear an oxford. The shoe should have at least five eyelets and have fairly good conformity around the heel. If the partial foot amputation is bilateral, the patient should select a shoe the size he previously wore. In most instances, the shoe salesman will tend to fit the bilateral amputee short, if the previous size is not known. In children with bilateral amputations, an estimation of their shoe size from their height and weight will have to be made, and cannot be accurately determined by fitting the stump alone. The patient is advised to purchase an established brand of shoes in a popular last, that has a wide pattern of shoes so that the prosthesis will fit various styles of shoes made over the same last. In women, a Miller shoe with a walker last seems satisfactory. This study, to date, has not included total contact restoration prosthesis for high styled women's shoes.

### Shoe Modifications

Shoe modifications are necessary for a Lisfranc's amputation or higher. If this type of prosthesis is to be constructed, the shoe modifications must be completed first, since the modifications place pleats in the shoe in a slightly different position than they would be normally. To add the necessary rigidity to the shoe, a steel spring, approximately one and one-half inches in width, is placed between the insole and the outsole of the shoe, from approximately the medial anterior border to the lateral posterior border of the shoe. The exact position is determined by the abducted gait of the patient. The steel spring can be placed in the shoe by merely opening a small section of the shoe at its medial anterior aspect and slipping the spring back between the insole and the outsole. The reason for the spring being in this position in the shoe is so that it will be in relation to the amputee's gait and his weight force will roll over the spring from lateral to medial during ambulation, and thus he will learn to use the steel spring in the take-off phase of gait. There is no outward appearance of the steel spring and it is in no way touching the patient's foot. The spring is very light and the additional weight is not apparent to the patient, as would be a full steel plate.

The shank will have to be reinforced since in a Lisfranc's and Chopart's amputation or higher, the patient's weight is concentrated on the shank of the shoe. A level bar, one and one-half inches in width, is placed longitudinally between the heel and the sole. This bar does not extend below the level of the heel or the sole, and creates a narrow wedge which reinforces the shank. The wedge is made of leather with a strip of rubber soling to prevent slipping. The shank reinforcement prevents deformity of the shoe and the forcing of the steel spring by the stump through the bottom of the shoe.

### Impression and Model

The areas of scarring and callous formation are marked on the stump with gentian violet. The level of the amputation determines the height of the impression over the stump. If the amputation is at the metatarsal phalangeal joints, it is extended to just below the ankle. If the amputation is transmetatarsal or higher, the impression

includes the ankle. The extent of the prosthesis in its total contact attachment to the stump is dependent on height of the impression. The higher the prosthesis grips the stump, the less slippage there is at the heel. A plaster impression of the stump is made with the use of six inch lengths of plaster of Paris, rather than using the entire lengths. Better conformity of the plaster to the stump is accomplished with short plaster splints. After the plaster of Paris splints have been applied to the stump, the plaster is split over the extensor surface of the stump and molded smooth. The stump is inserted into a plastic bag, and the shoe is then slipped onto the stump. The patient is instructed to take a few steps, and then stand in place on both feet, until the plaster of Paris sets. When the plaster sets, the impression is removed. Upon removal, the split portion is quickly remolded to the exact shape of the stump.

When the impression has completely dried, it is ready for the pouring of the plaster positive, the model. Dental stone is preferred to plaster of Paris, because plaster shrinks in proportion to the amount of water added. Dental stone, when mixed in a fairly hard consistency, has an expansion of one-tenth of one per cent and this compensates for the shrinkage of the latex. The dental stone is about ready to set, a steel rod is inserted, which aids in handling the positive during prosthetic construction.

### Impression of the Void Area of the Shoe

The inside of the shoe is lined with saran wrap. Dental stone is mixed to a fairly thick consistency. The dental stone is then poured into the shoe. While it is still wet, the model of the stump is placed inside the shoe, to obtain the exact relationship between the model of the stump and the void space of the shoe.

### Construction of the Mold

To accurately duplicate the void space of the shoe, a three-part mold will have to

Fig. 1 – Foam rubber extension being removed from three-part mold.

be constructed from the impression of the void area of the shoe. This is constructed in three steps so that the dental stone accurately encompasses the positive impression.

Dental stone is mixed in a firm consistency and poured into a puddle. The impression of the void of the inside of the shoe is pressed into the puddle and the dental stone is allowed to harden. Another small batch of dental stone is mixed and placed against the proximal portion of the impression and allowed to dry. A third batch of dental stone is mixed and poured over the remaining portion of the impression of the inside of the shoe and allowed to dry. After removal of the impression, a three-part mold is completed.

### Construction of the Forefoot Extension

The three-part mold is now ready to receive the liquid foam for the construction of the forefront extension. The liquid foam is made by mixing seven ingredients, as outlined by the manufacturer.[3] The manufacturer does not reveal the nature of the ingredients, but gives code numbers to the ingredients. The foam rubber can be made in different degrees of hardness or softness, by following the manufacturer's instructions. When the ingredients have been thoroughly mixed, they are poured into the three-part mold and placed in an

oven at two hundred degrees for three hours. The rubber hardens to the degree desired. The foam rubber extension of the prosthesis is now completed (Fig. 1).

### Preparation of the Stump Attachment

If desired, chamois can be placed over the model of the stump. This is not always necessary since some patients prefer to use a light stump sock. Zippers are placed on the model, behind the medial malleolus for a Lisfranc's amputation prosthesis or higher. The zipper can be sewn into either the chamois or the nylon that is used to reinforce the latex (Fig. 2). Tape is placed over the teeth of the zipper to protect it from the latex. The positive impression of the stump is dipped in latex approximately five times, allowing it to dry after each dipping.

Fig. 2 – Zipper sewn into chamois on stump model.

### Aligning of the Forefoot Extension With the Stump

The foam rubber extension and the latex-covered model of the stump are placed in the shoe. When proper alignment in the shoe is obtained, two lines are drawn from the foam rubber extension onto the stump to record the alignment. The foam rubber extension and the latex-covered model are removed from the shoe. If there are areas of scarring on the distal end of the stump, the proximal portion of the foam rubber extension is hollowed out in these areas to prevent trauma to these scars. Rubber cement is placed on the distal end of the latex-covered stump and the proximal portion of the foam rubber extension. The two pieces are placed together in proper alignment by matching the previously drawn lines (Fig. 3).

Fig. 3 – Foam rubber extension attached to latex-covered model of stump.

### Completion of the Prosthesis

With the forefoot extension fixed to the cured latex surrounding the stump, the entire prosthesis is dipped into liquid latex approximately five times. Nylon reinforcement is placed over the entire prosthesis for durability, during the dippings in liquid latex. If there are areas of excessive weight bearing on the plantar of the stump, sponge rubber paddings are placed between the layers of latex for protection.

After the latex is cured, the completed prosthesis is removed by trimming the excess latex liquid from the proximal portion of the stump. If a zipper is incorporated into the prosthesis, the latex is cut in this area and the protective tape is removed (Fig. 4). The prosthesis is fitted to the patient and usually no adjustments will be necessary due to the exactness of the casting technique employed. The patient is instructed to wash the prosthesis only in mild soap, such as ivory or woolyn, never in a strong detergent, and never allowed to soak. The prosthesis should be washed,

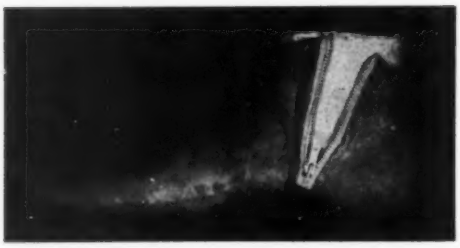

Fig. 4 – The completed prosthesis.

rinsed, dried and allowed immediately to air dry.

## Discussion

This study has developed a total contract restoration prosthesis which fits firmly and exactly around the remaining portion of the foot and provides an extension of the stump. This extension becomes a restoration and replacement of the amputated portion of the foot and assumes the greater portion of its function during weight bearing.

The materials used in this prosthesis are soft, resilient and light weight and do not place excessive pressure on the unamputated portion of the foot. The patient wears this prosthesis directly over his entire stump. A standard sock is then slipped on over the prosthesis and the stump. When the patient has his shoe off, it is not apparent that an amputation exists and consequently a good cosmetic result accompanies a good functional result. The patient can slip off his shoes, wear flexible footgear, such as slippers, and have some of the function that a normal foot might have, and the general appearance of a normal foot.

The construction of this prosthesis is such that it fits very accurately into the void space of the shoe and eliminates unsightly creases and wrinkles across the vamp of the shoe. These and other distortions of the shoe have in the past brought about a poor cosmetic result for those patients fitted with partial foot prostheses. The lightness and freedom of action of the total contact restoration prosthesis enables the patient to learn to use it during ambulation with a high degree of stability. In many instances, the amputee functions so well with the prosthesis that many gait problems are eliminated.

The materials used in the construction of the total contact restoration prosthesis are primarily latex and foam rubber which are relatively inexpensive. Once the initial prosthesis is constructed it is very simply and inexpensively replaced, by utilizing the original plaster models and molds.

Many patients with low level amputations seem to manage well at first with no prosthesis whatsoever. As the patient's gait accommodates to the missing portion of the foot, gait variations develop, which lead to severe muscular strain. These usually resolve themselves in some type of postural imbalance. The amputee should be fitted as soon as the stump is ready to receive the prosthesis.

## Case No. 1

This 59-year-old white male, with a diagnosis of diabetes mellitus, dating back to 1937, was admitted to Wadsworth General Hospital on November 29, 1956, with cellulitis of the left foot and gangrene of the second and third toes. Radiographic examination revealed no bone involvement. The patient was seen by the orthopedic service on December 5, 1956, and it was their opinion that below-knee amputation probably would be required. The patient was treated with saline soaks and antibiotics, and on February 28, 1957, the left second and third toes were amputated. The wound healed well. Subsequently, the patient developed gangrene of the fourth and fifth toes. On March 26, 1957, these two toes were amputated along with a portion of each of the lesser metatarsals. The patient was discharged to the domiciliary on May 14, 1957. On July 15, 1957, a total

Fig. 5 – Case No. 1.

contact restoration prosthesis was dispensed. The patient was immediately able to perform all ambulatory functions comfortably in a standard stock shoe with no apparent gait changes or outward visual evidence of the patient's deformity.

Comment: The ability of this restoration to conform to any irregular stump provided the patient's foot with a means to return to almost normal function and appearance and the prevention of a subsequent amputation at a higher level.

### Case No. 2

This 66-year-old white male was first seen on August 3, 1959, at which time he presented a history of an industrial accident in 1936, which resulted in crushing of the forepart of his left foot and also a head injury, for which he was hospitalized for six months. The patient stated that the foot "spit out" small pieces of bone for a long time. Four years following the accident a Choparts' amputation was done. Following the amputation a steel plate was placed on the entire outsole of the patient's shoe and was covered by an additional outsole and a felt filler was placed inside the shoe. At the time the patient was seen, he complained of foot and leg fatigue and pain in his hips, especially the left hip, after short periods of ambulation. During ambulation there was a noticeable dip to the left side. On October 19, 1959, a total contact restoration prosthesis was dispensed.

The patient was re-examined on November 4, 1959, at which time his limp was practically undetectable. The hip pain had subsided and he was able to ambulate for long periods without fatigue. The patient was seen on January 20, 1960, at which time he complained of moisture around the stump. Ventilation holes were placed in the prosthesis. On January 28, 1960, the patient's stump was re-examined. Ventilation appeared adequate and there was no evidence of maceration of the stump.

Comment: The patient's gait was markedly improved with the disappearance of the associated pain and fatigue by removing the filler and the heavy steel plate and adequately restoring the foot.

Fig. 6 – Case No. 2.

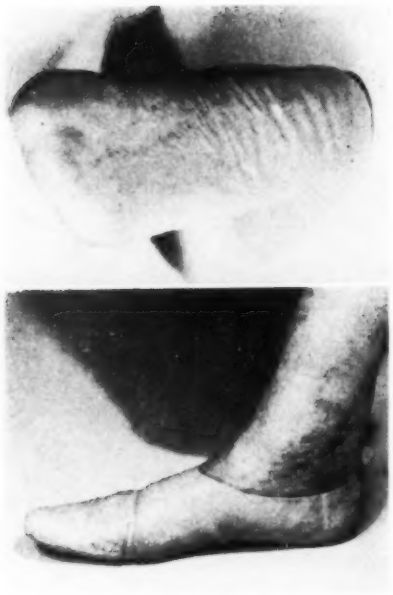

Fig. 7 – Case No. 3.

### Case No. 3

This 56-year-old white male was involved in a train accident in 1941, resulting in an amputation of all five toes of the right foot at the metatarsal phalangeal articulations. The patient was hospitalized for six months and was walking within two months. Since the amputation the patient had been wearing canvas shoes. He had not been able to wear any stock leather shoes because the wrinkle in the upper would irritate the stump. The patient had been provided with three pairs of custom shoes by the orthopedic shoe shop. Of these, he was only able to wear one pair, which contained a steel plate inside the shoe plus a filler. The patient was seen on April 3, 1956, at which time he complained of recurrent callous formations on the stump which required debridement at three-week intervals. On April 17, 1956, the patient was fitted with a total contact restoration prosthesis in a standard stock leather shoe. No shoe modifications were necessary.

The patient has been followed for the past four years and requires debridement of the callosities at five-month intervals and replacement of the prosthesis approximately every year.

Comment: Stabilizing the foot in the shoe with an adequate restoration retarded the callous formation and allowed the patient to wear any standard stock leather shoe. This is the lowest level of amputation for which a total contact functional restoration prosthesis has been constructed.

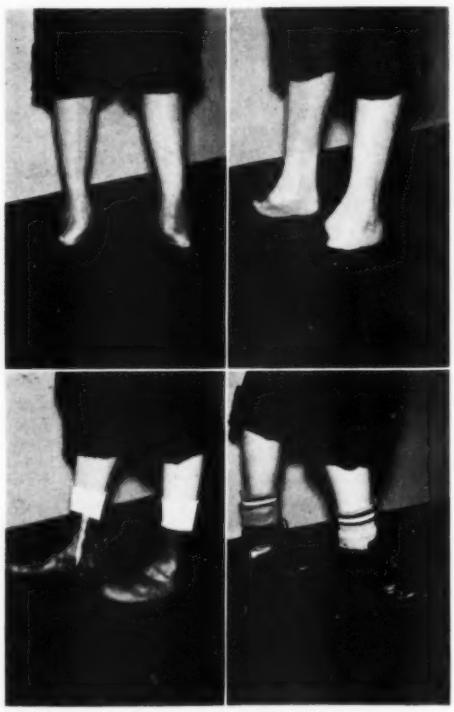

Fig. 8 – Case No. 4.

### Case No. 4

This 6-year-old white male was first seen on April 5, 1957. Congenital absence of both forefeet with accompanying minor oral and ocular deformities were present. The parents gave a history of the child being examined at the Mayo Clinic at the age of 5 months, and no definitive treatment was undertaken. The patient started

walking at the age of 18 months with hard sole surgical shoes. At the age of 3 years, a filler was placed in the shoe. Six months later this was discontinued, since the doctor whose care the child was under felt that it was unnecessary. The patient apparently ambulated well with a surgical shoe until the age of five and one-half. From this time on the patient would severely run over new shoes within two weeks. It was then that the parents began to seek further advice.

On examination, it was noted that the patient was wearing shoes which are approximately four sizes shorter in length than he should be wearing in comparison to his physical development. The parent stated that the child was frequently asked questions about his feet by his playmates, such as "Why are your shoes so small?"

Plaster impression casts of both stumps were taken on April 24, 1957. The prostheses were dispensed on May 20, 1957. No shoe modifications were necessary. The patient immediately accepted the prostheses. The gait improved to a point where there was no noticeable limp and the wear pattern of the shoes became normal. A clavus present on the distal end of the right stump completely disappeared within four weeks after wearing the prostheses. The parents observed a personality improvement in the child and there was no longer an apparent psychological problem in regard to his foot deformities.

The patient was seen at intervals of four months, at which time adjustments were made in the prosthesis for growth. Three subsequent prostheses were made at intervals of approximately every nine months with re-casting and construction of molds necessary for each prosthesis. Re-casting will be necessary for each prosthesis until the patient reaches maturity, at which time the prostheses can be constructed on an adult basis.[4]

Comment: The psychological rehabilitation of this patient was accomplished largely through the replacement of the missing body parts which enabled the patient to ambulate normally.

### Case No. 5

This 51-year-old white male was involved in a hunting accident in 1952, at which time a shotgun was discharged into his right foot. The patient was hospitalized for six weeks. During this time the greater portion of his foot was amputated, leaving only a portion of the calcaneus and talus, so that the leg appeared similar to a "peg leg," with an end weight-bearing stump. Following the amputation, the patient was fitted with a Syme's type amputation prosthesis that enveloped the small remaining portion of the foot and the lower leg to just below the knee. The prosthesis was heavy and bulky, being constructed primarily from molded leather and stainless steel.

The patient was first seen on October 2, 1959, at which time he complained of the uncomfortable prosthesis and the shoe deformity. He stated that the weight of the prosthesis tired him out, to a point where he ambulated frequently at home without the prosthesis. On October 23, 1959, the patient was fitted with a total contact restoration prosthesis. The steel spring was inserted into the shoe in a direct anterior posterior manner, since there was no forefoot and there did not appear to be external rotation of the extremity. A one-fourth inch lateral wedge was necessary on the shoe to prevent inversion of the prosthesis. The patient was immediately ambulatory and felt a greater freedom of movement and lightness.

On November 20, 1959, the patient was re-examined and it was noticed that there was no distortion of the shoe. The patient was not as conscious of his deformity and he was able to ambulate for longer periods.[5]

Comment: With very little of the patient's foot remaining, a prosthesis was constructed that restored most of the function of the foot and prevented any shoe distortion that would bring attention to

the patient's disability. The difference in weight between the two prostheses was eighteen pounds. This is the highest level of partial foot amputation for which total contact restoration prosthesis has been constructed.

**Summary:**

1. The literature was reviewed regarding methods of restoring lost portions of the foot.
2. The foot appliances in general use for partial amputations of the foot and the advantages of the prosthesis developed by this study are discussed.
3. An inexpensive method for construction of total contact restoration prosthesis for partially amputated feet is described in detail.
4. A total of fifteen patients have been treated. The average follow-up is four years, during which time the gait has been satisfactory and no further complications have developed.
5. Five case histories are reported to illustrate some of the various types of partial amputations of the foot.
6. The prosthesis described more adequately restores the lost portion of the foot and returns most of the foot's functional ability so that below-knee amputations will not be necessary in cases where only the disabled portion of the foot need be amputated.

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## COMBINED ORAL AND PERIARTICULAR TRIAMCINOLONE IN PODIATRY—A Preliminary Report

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***Triamcinolone, orally and concurrently by periarticular injection with Xylocaine, helped to relieve pain and restore normal function in 38 patients with rheumatoid arthritis, hallux rigidus and valgus, sesamoiditis and traumatic arthritis, without side effects. Detailed treatment and typical cases are described.***

One of the newer corticosteroids, triamcinolone,* when administered orally and at the same time periarticularly with Xylocaine,® helped to relieve pain and restore normal function in diseases of the joints and surrounding soft tissues of the feet. Although oral triamcinolone had previously been used successfully in relatively mild cases, it was believed that the periarticular injection of this drug would potentiate its systemic anti-inflammatory effect and the inclusion of Xylocaine would add a local anesthetic effect.

Triamcinolone is a highly potent glucocorticoid both in the laboratory and in clinical medicine. In its anti-inflammatory, hormonal and metabolic effects it often parallels the cortisone-like drugs from which it is derived. It deviates sharply from the older steroids, however, in its influence on sodium and water balance. Instead of causing retention, it either exerts no effect or produces sodium diuresis. In addition, it often depresses rather than stimulates ap-

*Supplied as Aristocort by Lederle Laboratories, Division of American Cyanamid Company.
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petite. Thus, it is applicable to the same conditions which have heretofore responded to the hydrocortisone derivatives, with several significant additions.

Patients from whom the benefits of steroid therapy have had to be withheld or limited because of edema, hypertension, or overweight will respond to triamcinolone without these adverse side reactions. In fact, patients who have experienced these reactions with the other steroids may lose their edema or excess weight, and become normotensive when switched to triamcinolone. As for its effects on conditions long-known to respond to this family of drugs, triamcinolone is more potent therapeutically than the earlier derivatives (such as prednisolone). It is effective in the same or lower doses in the treatment of rheumatic syndromes, and in significantly lower doses in pruritic and allergic syndromes. It is most active in the rheumatoid form of the arthritic diseases, although it has been observed to be of value also in cases of osteoarthritis, fibrositis and acute bursitis.

Included in the study reported below were patients with traumatic and rheumatoid arthritis and osteoarthritis. There were no cases of gout. A brief discussion of some essential facts about arthritis would seem to be appropriate here, since for proper treatment it is necessary to determine the type of arthritis, the tissues affected, and the extent of joint changes.

The foot is subjected to traumatic arthritis because of its weight-bearing function and the large amount of bony tissue in this part of the body. It is important to distinguish this primary type of arthritis from any of the systemic types. Various tissues may be involved in this disease, such as the periosteum, bursal sac, synovial membrane, muscle, and tendon. Hiss states that in primary arthritis the synovial membrane and bone marrow proliferate and cartilage degenerates. These processes tend to continue after the cause has been eliminated. Continued use of the feet, in the presence of these pathologic lesions, causes deformity and alters function.

Rheumatoid arthritis is best defined as atrophic arthritis. The joint changes are diffuse decalcification, atrophy of bone and cartilage, atrophy of interossei muscles, marginal erosion and synovial distention. Deformity ensues due to the degeneration of the metatarsophalangeal joints and the atrophy of the tiny muscles. The cause is not well understood. A relationship to infection, allergy, metabolic disorders, or endocrine dysfunction has been advanced but not proven. The joints of the feet are affected in rheumatoid arthritis and therefore are part of this study.

Osteoarthritis usually manifests itself locally, often in the joints of the feet. McGavack and associates recently stated that the distressing manifestations commonly involve one to three joints. With osteoarthritis alone there are no symptoms such as fever or tachycardia, the sedimentation rate is normal or only slightly elevated, and there is a leukocytosis; the joints affected are those that receive the greatest amount of trauma during life.

Bursitis is an acute or chronic inflammation of the bursa, usually found in association with joints. Bursae may be superficial, and if not necessary for function they may be excised and destroyed. Deep bursae are functionally important and are the type with which podiatrists are concerned. Bursitis may be caused by trauma and by acute or chronic infection. The cases included in this report were of the non-infectious group, and the bursae usually were located under the heads of the lesser metatarsal bones or associated with hallux valgus.

## TREATMENT

**General**—The localized treatment consisted of periarticular injections, supportive mechanical balance paddings, strappings, dynamic mold therapy, and ice packs. In preparation for the injection, 10 mg. of an

aqueous suspension of triamcinolone diacetate, or approximately 0.40 cc., was mixed in a 1 cc. tuberculin syringe with sufficient Xylocaine 2% (containing 1:100,000 epinephrine) to make 1 cc. Since these two chemicals are compatible they may be mixed with impunity. It has been found that this mixture (using the same proportion in a larger size syringe) can be injected without the danger of pooling the concentrated triamcinolone, thus permitting the injection of a greater quantity of solution into large areas such as the ankle. Care was taken to inject at a slow rate and fan out the solution. Whenever it was possible to reach a plantar area from the dorsal or lateral aspect, the plantar surface of the foot was never punctured by a needle. It is to be noted that at no time were intra-articular injections performed.

In conjunction with the local treatment, triamcinolone was administered by mouth, usually in the following dosage: 2 mg. q.i.d. for two days, 2 mg. t.i.d. for 2 days, 2 mg. b.i.d. for 2 days, 1 mg. b.i.d. for 2 days, and then 1 mg. (half a scored 2 mg. tablet) a day for one week. If there was no pain during the time the patient was receiving 1 mg. per day, this was considered to be the sustaining dosage and was continued as long as necessary. If the patient was more comfortable at a higher dosage level, that dosage was continued, and reduction attempted when the symptoms subsided. Likewise, there was no set rule as to the amount of injections required for any specific ailment. Rest and general medical treatment were prescribed when indicated, in collaboration with the internist, orthopedist or family physician. Moreover, it was considered expedient to consult with the family physician prior to administering triamcinolone orally.

Steroids injected periarticularly exerted no systemic action in the dosage used, but appeared to allow a reduction of the dosage of corticosteroids given systemically. No side effects were seen during this study, probably because the dosage of triamcinolone was lower than that usually recommended.

X-rays were taken in all cases, especially when trauma was part of the history. This was necessary to rule out fractures and to determine the extent of joint damage or change. Comparative x-rays were taken wherever possible.

The method of treatment just described is applicable primarily to arthritis and bursitis, but is also used in hallux rigidus, hallux valgus, and sesamoiditis. However, treatment of the last three conditions involves special techniques, which will be described below under the corresponding headings.

**Hallux Rigidus**—After completely bathing the periphery of the great toe joint by means of lateral and dorsal periarticular injections, a stiffening material (Celastic) is added to a leather shell that was shaped to the contour of the plantar surface of the foot and was secured in place by rubber bands over the toes. The Celastic material was applied longitudinally on the bottom surface of the leather along the shaft of the first metatarsal and the great toe. Dorsiflexion was then limited while the foot was in motion. This therapy combined with oral triamcinolone and a shoe that did not press or break on the joint (dorsally) resulted in continuance of a pain-free area. At least three injections were necessary in the six cases under care. These injections were spaced three to four days apart; 1 cc. of the combined solution was injected at both sites each time. One patient required seven injections for complete relief of pain. It is interesting to note that when the foot was pain-free, greater motion was well tolerated without return of the pain.

**Hallux Valgus**—Arthritic joints and those associated with bursal involvement were cared for in this study. Where a bursal sac was distended and the joint was painful, these conditions were treated simulta-

neously. When necessary the sac was infiltrated with the Aristocort-Xylocaine solution and distended. A large gauge sterile needle was used to aspirate the fluid, and a minimal amount of the solution (0.2 to 0.4 cc.) was re-injected into the sac. Injections of 1 cc. of the combined solution were made medial, lateral, and posterior to the joint, and triamcinolone was administered orally at the same time. Ice packs were prescribed for 15 minutes at intervals of one hour for at least twenty-four hours. Complete removal of shoe pressure was advised until the acute phase passed. When joint pain was not associated with a bursal inflammation, the injections were administered by the same method at three and four day intervals. A joint-traction exerciser was used daily to stretch the joint capsule and tissues about the joint and to increase the range of motion.

**Sesamoiditis**—In treating sesamoiditis it is very important that the area be relieved of all weight-bearing pressure if the patient is ambulatory. With the employment of oral and periarticular triamcinolone, it is possible for the patient to maintain a normal schedule and be pain-free. A lateral balance pad of wool felt with an extension posterior to the sesamoid bones (Dancers pad), which was sufficiently thick to alleviate the pressure on the inflamed area, was attached to the foot. Inflammation and pain were relieved promptly when injections were made laterally (to reach the external sesamoid) and dorsally in the first and second intermetatarsal spaces (to reach the medial sesamoid). If necessary, a Fay Bar was attached to the sole of the shoe. The injections were continued until all symptoms subsided, and the dynamic mold therapy was employed to prevent recurrence.

## CASE REPORTS

A total of 38 patients were treated. The following case reports illustrate the method and results in three of the aforementioned conditions, namely, hallux valgus, hallux rigidus, and sesamoiditis.

**Case I.** A 53-year-old woman slightly overweight and wearing high heel (3 inch) dressy pumps, presented herself with a red and swollen hallux valgus of the right foot. Her only complaint was pain in the hallux joint. She had a Shaffer-type foot with subluxated toes. X-rays revealed a deviation of about 30 degrees of the right toe. The left toe showed a slight deviation without symptoms. Marginal lipping of the first metatarsal head indicated a chronic infection, and definite osteoarthritic changes were present. The deviation of the first metatarsal bone created an imbalance, allowing the second metatarsal to extend forward of the first. The imbalance was cared for by corrective padding.

On June 9, 1960, a series of periarticular injections were initiated. Two 1 cc. injections of the triamcinolone-Xylocaine solution were administered, one dorsally between the first and second metatarsal heads, the other lateral and posterior to the head of the first metatarsal bone.

Wider and longer shoes were recommended, plus ice packs as often as possible for the next twenty-four hours. Oral Aristocort, 8mg. daily divided into 4 equal doses, was prescribed after consulting with her physician. After 3 days the dosage was reduced to 6 mg. per day, and then gradually to 2 mg. per day. The patient was away for 11 days on a trip and was unable to continue with the injections or balance pads, but she did alter the size of her shoes. On her return on June 21, 1960, she reported that she had no discomfort. Upon examination the redness and tenderness were gone, and treatment was discontinued except for a permanent balance pad.

**Case II.** A 62-year-old woman of average weight, who had been under a physician's care for a generalized arthritic condition, complained of excessive pain of long duration in the hallux joints of both feet. She

said that many attempts of therapy in the past years had been unsuccessful. Examination showed limited dorsiflexion of the great toes, and widening of bones of the hallux joints. A red line of depression was present, apparently caused by shoe pressure. The diagnosis was hallux rigidus with an associated osteoarthritis, which was confirmed by lateral and dorso-plantar X-rays.

On January 29, 1960, the first of a series of injections was given. The entire area lateral and posterior to the joint was injected with 3 cc. of the triamcinolone-Xylocaine solution. After consultation with lateral and posterior to the joint was inministered at the dosage of 8 mg. per day in 4 divided doses. The daily dose was reduced after 4 days to 6 mg., then 4 days later to 4 mg. and finally to 2 mg., which was maintained until July, 1960. Shoe and sling therapy were also utilized. Injections were given every 4 days for a total of five visits. By the third visit the patient was practically pain-free. On March 25, 1960, she said that she had a greater range of motion with little or no pain.

**Case III.** A 45-year-old woman of average height and weight, wearing medium-heeled pumps, came limping into my office with pain in the right great toe. She had missed a step getting off the bus that morning and had landed on the ball of her right foot. The pain had been intense for a moment, but she continued on to her place of work. By noon her foot was swollen and very painful. She gave a past history of periodic pain in the hallux area of both feet, especially when she wore high-heeled shoes, but this pain decreased when she changed to lower heels for a few days, using a foam rubber pad under the sore area. Examination showed swelling and redness of the right first metatarsophalangeal joint, which could not be palpated because of the tenderness. Dorso-plantar and lateral x-rays revealed a split medial sesamoid on the right foot with subluxated toes and thickened fullness of the first metatarsophalangeal area. A diagnosis of traumatic sesamoiditis of the right foot was made.

The patient was given ten 2 mg. tablets of Aristocort to be taken every 6 hours, and was instructed to apply ice packs for 15 minutes every hour and to elevate the foot. Two days later she returned to the office with only slight pain. Injections of 1 cc. of triamcinolone-Xylocaine solution were made dorsally between the first and second metatarsals toward the medial sesamoid, and laterally toward the external sesamoid. A lateral balance pad (Dancers pad) of 3/16 inch wool felt was strapped to each foot. A new shoe size was ordered to accommodate the balance pads. The injections were repeated at 3-day intervals and the padding was replaced on the feet each time. On June 21st the patient had no pain. A transfer balance pad was made that was removable from shoe to shoe. The patient was instructed to use low heel shoes to allow complete healing of the injured part.

This is intended to be a preliminary report. Since triamcinolone has been effective in some patients when given either orally or by periarticular injection, another study is in progress to determine the value of each method of administration alone.

## Summary

The use of triamcinolone, by mouth and at the same time by periarticular injection with Xylocaine, helped to relieve pain and restore normal function in 38 patients with rheumatoid arthritis, hallux rigidus, hallux valgus, sesamoiditis, and traumatic arthritis. No side effects were noted. The method of treatment described here appears to produce better results than methods previously employed, especially in more severe cases, and warrants further study in these diseases.

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## A NEW DERMATOLOGIC AGENT FOR HYPERIDROSIS AND BROMIDROSIS—A Preliminary Report

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Hyperidrosis and bromidrosis of the feet have long presented interesting and challenging problems to the podiatrist. Experience has shown that the incidence of dermatologic disorders has increased immeasurably during the past decade. Hyperidrosis is a clinical entity which may include localized dermatologic changes and concomitant secondary infections of the foot as well as some systemic changes related to neurocirculatory disorders. In practice it is a significant source of disabilities among large segments of the population, and accounts for a major portion of patient complaints at the office practice level. The average person is more concerned with skin disorders of his feet, especially bromidrosis and maceration, than with an underlying orthopedic fault or metabolic defect which may have originated the skin disorder. Therefore, prompt and effective treatment of the skin disorder is required to gain patient confidence and cooperation, and ultimately correction of the fundamental foot disorder may be attempted as circumstances permit.

Unfortunately, the treatment of dermatologic disorders of the feet is difficult and generally the procedures currently employed to modify the course of the disease are empirical at best. Frequently, topical medications are employed in an attempt to minimize secondary infections and prevent spreading of vesiculations.[1] Soothing compresses are helpful, especially in the early stages of the disease, and emollient creams employed in chronic conditions may reduce pruritus as well as spread of the superficial lesions. The benefits derived from the foregoing procedures are variable and the therapeutic values are questionable. Obviously, no further irritation of the skin in the affected areas should be permitted, and wherever possible, precautionary steps should be taken to prevent deep-seated infections.

Regardless of the primary cause of the skin disorder, hyperidrosis is invariably associated with injury of the outer layers of the skin, and it is most difficult to control.[2] No satisfactory method has yet been devised to combat the excessive moisture which seeps over the affected skin surfaces. Usually, the first step in therapy is to eliminate the primary irritants, especially factors which increase sweating. The best known dermatologic hazard is an ill-fitting shoe. Indeed, many podiatrists contend that a majority of dermatologic disorders of the

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## TABLE I

### Protocol of 42 Cases Treated with Methenamine Undecylenate

| Occupation | Age Sex | Presenting Symptoms | General Health | Treatment Period | Remarks | Results | Side Effects |
|---|---|---|---|---|---|---|---|
| Practical Nurse | 56F | Hyperidrosis, clammy skin | Tense, nervous, perspires rapidly | 3 wks. | Poor cooperation | No change | None |
| Dental Assistant | 40F | Mild hyperidrosis | Normal | 6 wks. | Poor cooperation | No change | None |
| Housewife | 35F | Hyperidrosis, vesicular patches on hand and feet | Tense and peptic ulcer | 2 wks. | Skin drying in 5 days, also hands improved | Excellent | None |
| Steelworker | 41M | Inflamed skin, fungus with severe hyperidrosis | Good | 3 wks. | Skin drying, infection subsided | Excellent | None |
| Schoolboy | 9M | Hyperidrosis and bromidrosis | Good | 2 wks. | Rapid recovery, recurrence of hyperidrosis and odor after discontinuation of NPL-8 | Excellent | None |
| Schoolboy | 12M | Atopic dermatitis | Good | 8 wks. | Good drying effect | Excellent | None |
| Stenographer | 44F | Hyperidrosis | Good | 4 wks. | Good drying effect | Excellent | None |
| Schoolgirl | 11F | Fungus interdigital, maccular type fungus | Good | 5 wks. | Skin crusted and nails pitted, good drying effect | Excellent | None |
| Dental Assistant | 36F | Mild hyperidrosis (no odor) | Good | 8 wks. | Fair cooperation | Excellent | None |
| Factory Worker | 29F | Hyperidrosis and latent fungus | Good | 8 wks. | Cotton socks no longer stiff, no odor | Excellent | None |
| Secretary | 34F | Macerated and wet toes | Good | 5 wks. | Poor cooperation | No change | None |
| Dairy Worker | 66M | Severe hyperidrosis, maceration between toes | Some arthritis | 7 wks. | Previous formalin Rx no help | Excellent | None |
| Schoolboy | 10M | Virus dermatitis, dorsum of toes | Good | 8 wks. | Coal tar ineffective | Excellent | None |
| Bank Clerk | 47F | Moderate hyperidrosis, plantar vesicles | Good | 7 wks. | Dermatitis subsided, feet much dryer | Excellent | None |
| Dairy Worker | 55M | Hyperidrosis, long standing | Good | 4 wks. | Definite improvement, feet no longer cold in boots | Excellent | None |
| Steelworker | 53M | Hyperidrosis, some odor | Good | 8 wks. | Poor cooperation, preferred Quinsana® | No change | None |
| Housewife | 59F | Fungous vesicles and atopic dermatitis | Good | 4 wks. | Definite improvement | Excellent | None |
| Nurse | 45F | Hyperidrosis (uncomplicated) | Good | 4 wks. | Poor cooperation | Improved | None |
| Schoolboy | 16M | Multiple warts, wet clammy feet | Good | 5 wks. | Previously resistant to bandages, too wet. Warts severe | Excellent regression of warts | None |
| Housewife | 51F | Interdigital macerations, hyperidrosis, bromidrosis | Good | 2 wks. | Not cooperative. Used powder occasionally | Fair | None |
| Schoolboy | 14M | Active dermatophytosis, vesicular eruptions, interdigital fissures | Good | 4 wks. | Reduced sweating with NPL-8, then used $AgNO_3$ on warts. Both fungus and warts gone | Excellent | None |
| Shipping Clerk | 41M | Severe hyperidrosis, red sensitive skin | Good | 3 wks. | Rapid improvement | Excellent | None |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Shipping Clerk | 41M | Severe hyperidrosis, red sens'tive skin | Good | 3 wks. | Rapid improvement | Excellent | None |
| Housewife | 56F | Interdigital mycosis infection with maceration | Good | 6 wks. | Uncooperative | Poor | Interdigital fissures with drying |
| X-ray technician | 30F | Hyperidrosis, bromidrosis and erythema | Good | 6 wks. | Rapid improvement, soothing and drying | Excellent | None |
| Housewife | 42F | Hyperidrosis, mild fungus on skin and nails | Good | 4 wks. | Much improved | Excellent | None |
| Social Secretary | 47F | Hyperidrosis | Good | 4 wks. | Marked improvement | Excellent | None |
| Housewife | 37F | Hyperidrosis, bromidrosis | Good, nervous type | 4 wks. | Improved | Excellent | None |
| Housewife | 54F | Hyperidrosis (mechanical balance inlays) | Good | 3 wks. | Cooperative, rapid relief of sweating | Excellent | None |
| Secretary | 45F | Dermatitis of 1st great toe, hyperidrosis, bromidrosis | Fair | 3 wks. | Makes walking easier, soothes feet | Excellent | None |
| Housewife | 59F | Hyperidrosis, pruritus, arch and heel | Good | 4 wks. | Relieved pruritus and drying effects noted | Excellent | None |
| Grocery Store Owner | 50M | Hyperidrosis, pruritus and interdigital fissures | Good | 2 wks. | Itching and sweating stopped. Improved promptly | Excellent | None |
| Executive | 55M | Interdigital fungus, pruritus, moist, weeping | Good | 2 wks. | Improving, favorable drying action | Excellent | None |
| Housewife | 30F | Severe hyperidrosis, some bromidrosis | Good | 3 wks. | Pleased with powder, no odor as feet become dry | Excellent | None |
| Restaurant Owner | 54M | Hyperidrosis, severe orthopedic problem | Good | 8 wks. | Had "tried everything," but NPL-8 helped | Excellent | None |
| Schoolboy | 15M | Hyperidrosis, chemical dermatitis and dermatophytosis | Good | 3 wks. | Skin became dry and scaly. Stopped NPL-8 powder | Excellent | Slight flaking and chapping of highly sensitive areas |
| Chemist | 50M | Hyperidrosis, interdigital epidermophytosis | Good | 4 wks. | Completely cured | Excellent | None |
| Housewife | 53F | Hyperidrosis, interdigital macerations | Obese | 4 wks. | Improved | Excellent | Ankle became dry and shiny —friction? |
| Schoolboy | 13M | Severe hyperidrosis (balance inlays) | Good | 1 wk. | Markedly improved, skin tone much better | Excellent | None |
| Barber | 48M | Plantar corn and mild maceration with moisture, small fungous patch on left foot | Good | 4 wks. | Drying effects of NPL-8 plus supportive shoes—improved promptly | Excellent | None |
| Governess | 55F | Hyperidrosis | Good | 2 wks. | No further perspiring of feet, patient happy with improvement | Excellent | None |
| Surgeon | 48M | Hyperidrosis, severe bromidrosis, interdigital and plantar maceration | Good | 4 wks. | First improvement in years, better than formalin soaks | Excellent | None |
| Physician | 31M | Severe hyperidrosis erythema, maceration | Good | 4 wks. | Only agent that ever helped, especially when wearing molded shoes | Excellent | None |

human foot may be traced directly to the wearing of footgear. An ill-fitting shoe causes trauma of the skin and should be corrected in every instance to provide a suitable environment for tissue repair with a minimum of perspiration. However, correction of the footgear is not enough to restore normal functions to the skin. Another important cause of excessive sweating is clothing made of synthetic fibers. Such fabrications, especially nylon hosiery, can absorb little or no moisture and consequently allow offending films of sweat to accumulate and act as irritants of the affected skin.

Good foot hygiene is a prime requisite in management of hyperidrosis. Every podiatrist recognizes the need for controlling hyperidrosis as the first step toward proper healing of the skin. Actually, this goal is difficult to achieve and the course of treatment is exacting and prolonged. Systemic medications with the various anticholinergic drugs usually have only modest effects on hyperidrosis of the extremities, while the undesirable side effects are well known. Sedatives and tranquilizers help occasionally, but for the most part these drugs are entirely inadequate in hyperidrosis of the feet. Soaking the foot in a dilute formalin solution may provide temporary control of the hyperidrosis, but this procedure is best restricted to use in chronic conditions where there is no obvious denudation of the skin.[3] The latter method is time-consuming and requires careful supervision and full cooperation by the patient.

Despite the great advances of recent years in the development of chemotherapeutic agents, little progress has been made in the control of dysidrosis associated with common foot disorders. Neither anti-inflammatory steroids nor the potent non-toxic antibiotics have contributed much toward alleviating the unphysiologic sweating that interferes with therapeutic procedures in foot care. The situation demands further research in dermatology and podiatry to determine possible clues concerning the nature of the pathophysiologic processes. Consequently, the topical drugs that act specifically on dermatologic mechanisms should be evaluated.

The recent synthesis of a new compound, methenamine undecylenate, that exerts a drying effect on the skin was reported last year.[4] Preliminary clinical trials indicate that it is a useful dermatologic agent. Since the investigation of new drugs having therapeutic application in podiatry is an important function of the podiatry clinics at university hospitals, a group of staff members at Buffalo General Hospital undertook an evaluation of this new compound. The results of clinical trials to date are reported here.

Conventional methods of investigation were employed throughout this study. Patients were randomly selected, one series at the diabetic foot care clinic of the Buffalo General Hospital, and others among patients of the participating investigators. The preliminary condition of the feet was ascertained and suitable candidates exhibiting hyperidrotic dermatoses were included in this study. Each patient was instructed equally concerning foot hygiene, hosiery and shoes. Wherever possible, individual adjustments of footgear, braces and bandages were made in order to equalize conditions. Previous experiences under similar conditions of environment, occupation and medications served as controls. After an initial two-week period of observation, each patient was given a supply of the test drug† with instructions to apply the powder liberally on affected areas every morning and night. Also, recommendations were made to dust the stockings and shoes as often as required to maintain relatively dry surroundings. A small number of patients were instructed to use an ointment preparation containing methenamine undecylenate (5%) for nighttime control of extremely moist and inflamed areas. Another small

group wore bandages to meet individual requirements.

Clinical observations were made over periods ranging from two weeks to five months. Forty-two representative case histories are presented in Table I with results analogous to those obtained for the total 107 patients (Table II): Excellent 89; improved 8; no significant change 8; side effects 2.

Ninety-one percent of the total patients treated for hyperidrosis and bromidrosis responded satisfactorily to the new drug, methenamine undecylenate. Minor side effects occurred in two patients, one having deep heel fissures and the other having a known chemical sensitivity and possible allergy to dusting powders. The results are summarized in groups divided according to the investigator making observations.

**TABLE II**
**SUMMARY OF RESULTS**

| Cases | Response to Therapy (NPL-8) | | | |
|---|---|---|---|---|
| | Excellent | Improved | No Change | Side Effects |
| 21 | 13 | 4 | 2 | 2* |
| 19 | 19 | | | none |
| 18 | 12 | 3 | 3 | none |
| 10 | 8 | 1 | 1 | none |
| 25 | 24 | | 1 | none |
| 14 | 13 | | 1 | none |
| 107 | 89 | 8 | 8 | 2 |

* #1 Deep heel fissures. #2 Allergy combined with chemical hypersensitivity.

### Representative Case Histories

**#22**—H. B., Age 41, Male, Shipping Clerk. Flat feet, second degree, bilateral, severe hyperidrosis, interdigital maceration plus redness of entire plantar surface and heels. When first seen, this patient walked with difficulty and could not work while standing on his feet. His general body posture was poor and he shuffled as though carrying a heavy weight. His mental outlook was poor and he was discouraged to the point of quitting his job. NPL-8† Powder was used morning and evening and at bedtime with frequent changes of socks. Within 12 days, the redness had disappeared and the perspiration had decreased considerably. "Flexible casting" for correction of his orthopedic problem was then initiated. He continued to use the powder on areas around the adhesive straps. It should be noted that previous attempts to employ supportive bandaging had failed because excessive moisture interfered. Application of NPL-8 powder reduced sweating and permitted good strapping which, in turn, helped to correct his orthopedic faults. The patient remained ambulatory throughout the course of treatment and both his physical and mental outlook improved. Mechanical supportive therapy and proper footgear have continued to maintain this patient.

**#19**—W. L., Age 16, Male, Schoolboy. Multiple warts, skin generally wet and clammy, severe hyperidrosis a complicating factor. Previous treatment of the warts including chemical cautery, cryotherapy, etc., had been unsuccessful. All efforts to treat verrucae were suspended with the exception of weekly applications of 60% silver nitrate. Specific treatment of the hyperidrosis was started and consisted of liberal application of NPL-8 powder (5% methenamine undecylenate) morning and evening, and cotton socks to be changed at least once daily. Within one week improvement in the texture of the skin was noted and sweating had subsided. Treatment was continued for one month, hyperidrosis was no longer a significant factor. The warts disappeared and the patient was discharged as cured.

The restoration to health of integument so that is has the ability to "throw off" a noxious agent seems to the author to be an important goal of therapy. In many instances, once the skin is restored to normal function, verrucae will subside and disappear with conservative treatment.

### Discussion

The excellent results obtained through the use of the new dermatologic agent,

†Supplied by Nordson Pharmaceutical Laboratories (NPL-8, methenamine undecylenate 5%).

methenamine undecylenate, raises the obvious question, "What therapeutic mechanism is at work?" Normally, the stratum corneum of the sole functions to provide water-homeostasis with keratin playing an important role in this process. Dyshidrosis is an abnormal function of the keratin layers in which the disturbed water-balance leads to hyperidrosis. This pathophysiology of palmar/plantar stratum corneum has been elucidated by several investigators.[5, 6] Changes in the so-called "Barrier Zone" of the sole are responsible for the commonly severe and persistent dermatologic disorders. When excessive amounts of perspiration are permitted to accumulate on the skin surfaces, the excretory processes may be reversed. Relatively large amounts of sweat move intradermally and produce supersaturation of the keratinous barrier of the epidermis. Nonerythematous vesicles soon form and coalesce, spreading through the epidermal layers of the plantar surface. The intradermal perspiration blocks the sweat ducts causing them to rupture. This engorgement of the superficial layers is characteristic of hyperidrosis. We recognize the water-logged, clammy foot which weeps constantly and floods the sole and interdigital areas with an offending film of moisture. This film provides an ideal medium for bacterial and fungous growth and secondary infections. Bromidrosis is prevalent under such conditions. Reversal of these pathophysiologic processes is usually difficult to achieve since moisture serves as a primary irritant and inevitably retards healing processes.

The action of methenamine undecylenate in topical treatment of hyperidrosis is based on active therapeutic agents favorably modifying the water-barrier processes so that normal physiologic processes may be reestablished. Hydration of the compound releases methenamine and undecylenic acid. The methenamine dissociates further to yield minute quantities of formaldehyde plus a series of methylol amines which in turn serve as a source of additional formaldehyde as more water enters the chemical system. It is these agents that exert drying and antibacterial effects. At the same time, the undecylenic acid component acts as a buffer and a powerful antifungal agent. The total effect is synergistic: astringent, antibacterial, antifungal and emollient.

## Summary

Problems of treatment and care of the hyperidrotic foot have been outlined. Clinical trials in a wide variety of dermatological disorders of the feet employing a new association salt, methenamine undecylenate, have been reported.

Clinical experiences have demonstrated the therapeutic potentials of methenamine undecylenate. The controlled release of active agents, formaldehyde and undecylenic acid in effective but subtoxic concentrations provides a means of treatment of hyperidrotic dermatoses with relatively little irritation of the skin.

Further clinical trials in a wide variety of dermatologic conditions involving defects of the water-barrier seem to be warranted. On the basis of our experiences, this new topical agent offers distinct advantages for satisfactory control of the excessively moist skin. Also, the use of these new preparations permits the podiatrist to employ supportive bandaging without the interference usually met in conditions of hyperidrosis. Clinical improvements in 91% of the patients using this topical medication suggest a real advancement in management of the common foot disorders, hyperidrosis and bromidrosis.

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## CLINICALLY SPEAKING

*A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.*

### ELECTRICAL BURNS OF THE FEET
#### A Case Report

LOUIS J. SHAPIRO, D.S.C.*
Albuquerque, N. Mex.

A BOY, age 11, was seen and examined in the hospital on May 3, 1960. According to his history, he was injured on May 1, 1960, while on an outing with his parents. He stated that he was playing a short distance from his parents when he picked up a line (7,200 volts of electricity, according to the Public Service Company of New Mexico) to toss it aside and the next thing he knew he says, "I went to sleep." He stated he awoke and began to get up on his feet and went to sleep again. When he awoke for the second time, he called for his parents and they came to his aid. At the time, the only noticeable discomfort was a severe burning pain of his left hand. According to his mother, he was carried or taken to a nearby Ranger Station for first aid and from there to the emergency room of the hospital.

At the time of my examination, the patient stated that both his feet and left hand were painful and numb. The patient stated that his pain was mostly confined to the small toes of his right foot and the big toe of his left foot.

Examination revealed a fairly well developed young male. He had third and fourth degree burns of the dorsal surface of the right foot from approximately the middle of the foot to the distal ends of the toes. There was a great deal of necrotic tissue with vesication and charring. The fascial layer was completely destroyed over the extensor tendons leading into the second, third and fourth phalanges. The entire distal end of the first, second, third and fourth toes was charred. The nails of the second and third toes were loosely attached by a small piece of tissue. The nail of the first toe was elevated and may be lost along with the second and third. The second and third toe had an unusual flattened appearance.

Both sharp and dull instruments were used to test sensation which was found to be hyperactive. This, I believe, was caused by the extreme tenderness and sensitivity of the area. Active and passive motions of dorsi- and plantar flexion, inversion, eversion, adduction and abduction were tried and found to be slightly limited. Reflexes of the leg and foot were hyperactive and a small amount of contracture was noted at the crest of the toes. There was no paralysis (although it was present when admitted) at this time. His vibratory sense was good and there were no areas of anesthesia, but there was some paresthesia on the dorsum of the foot. The dorsalis pedis and posterior tibial were palpated and of good

* Associate Staff Member Osteopathic Hospital

quality. The skin temperature was warm.

The left foot had the entire medial border of the great toe charred and a deep groove which exposed the capsule of the phalangeal joints. The superficial and deep layers of the skin over this area were completely destroyed. The deep structures appeared macerated and dull white in color. The nail was still firmly attached. On the plantar surface of the heel was an area of one-half centimeter in diameter which resembled a puncture wound and was charred around its circumference.

Active and passive motions were limited on both dorsi- and plantar flexion of the great toe. All other motions were within normal limits. Reaction to both dull and sharp instruments was good as was the vibratory sense. Reflexes were hyperactive on both leg and foot. The dorsalis pedis and posterior pulses were of good quality. There was no paralysis and the skin temperature was warm.

Radiographs were negative for bone pathology on both left and right feet.

This patient sustained third and fourth degree burns of both feet due to an electrical current. There has been a great deal of destruction to both superficial and deep tissue, but the extensor tendons of the right foot so far have remained intact. The patient has no paralysis and feels both dull and sharp sensation to his feet. His motions are limited and his reflexes are hyperactive.

**Treatment**

The patient was hospitalized for a period of 10 days, during which time he received the following treatment. Moruguent®[1] sterile gauze dressings with a top covering of one inch elastic bandage carried to the knee. Albamycin®[2] 250 mg. q 6 h and h.s., V-Cillin K®[3] 300,000 units daily, and Prednis C.V.P.®[4] one capsule t.i.d. The patient was given Demeral®[5] 25 mg. IM for pain q 4 h p.r.n. A screened cage was placed over the patient's feet so that the top sheet would not bear weight on the burned areas and the feet elevated. Dressings were applied under sterile conditions and the procedure repeated every three days until healthy granulation tissue developed. The patient was placed on a high protein diet and given fruit juices four times daily. The fourth day after admittance the patient's bandages were changed. There was an extremely foul odor and several large blisters had formed on the dorsum of the right foot. Preliminary cultures were taken from the burned areas, and a debridement of all wounds was carried out. Only the closed method of treating burned areas was used. In instances in which dressings were applied, this procedure was carried out immediately. These dressings were saturated with the antibiotic Neosporin®[6] so that bacterial multiplication was inhibited. Thereafter, fresh dressings were applied every three days until healthy granulation tissue developed. Thirty-five days after the initial insult when the cultures were negative for bacterial infection, Pantho-Foam®[4] was applied to the wounds and covered with Telfa®[7] dressing and this wrapped with elastic bandage carried to the knee joint. Pantho-Foam proved to be an excellent agent which reduced inflammation, greatly lessened the production of proud flesh, and reduced keloid formation. Its ease of application from an aerosol dispenser and the evenness with which it spreads over the wound area without discomfort to the patient, makes it a most useful drug to have in our office armamentarium.

As the patient progressed, medication was changed to the Pantho-F cream. The extensor tendons of the second and third toes were holding the toes in a dorsi-flexed attitude. A toe sling was fashioned to hold the toes down in an over-corrected plantar-

®[1] Massengill Co.
®[2] Upjohn Company
®[3] Eli Lilly & Co.
®[4] U. S. Vitamin Corp.
®[5] Winthrop Laboratories
®[6] Burroughs Wellcome & Co.
®[7] Bauer and Black

flexed position. Ambulation was not begun until there was an appreciable amount of granulation tissue and then only with crutches. A pair of shoes was prepared with the entire top covering removed up to the laces on the right shoe and the medial portion of the top covering on the left shoe. The sock liner of both shoes was relined with 1/8-inch sponge rubber and the upper part of the inner shoe relined with 1/16-inch adhesive sponge rubber. Foot and leg exercises were begun as healing progressed to prevent atrophy.

**Prognosis**

It is felt that the patient has made a slow, but good recovery and with the further passage of time, a complete healing of all the burned areas will be achieved. The patient is fully ambulatory and is now wearing regular oxfords with the minimum of bandages. Pantho-F cream is still being used to decrease the amount of scar which has formed on the dorsum of the right foot. The second and third toes of the right foot are still being held in an over-corrected plantar-flexed attitude, but it is doubtful that this alone will bring about a good result. A "Z" skin plastic procedure with a tendonectomy is being considered. On August 5, 1960, an X-ray was taken of the right foot and the distal phalanx of the second toe appears to be smaller in size than the other phalanxes of adjacent toes. The growth process seems to have been delayed. The second and third nails of the right foot have not yet made their appearance.

*2130 San Mateo, N. E.*

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## GLOMUS TUMOR—A Case Report

HOWARD RAUCH, Pod.D.
Brooklyn, N. Y.

ALTHOUGH the most common site of the glomus tumor is subungual, it does occur elsewhere. Presented here is a report of a glomus tumor found in an unusual location.

A white female, age 16, was referred to this office by her family physician with a history of a "wart" on the left heel for the past six months. She had received several electrical desiccation treatments without apparent benefit.

Examination of the right foot revealed a plantar wart at the outer border of the heel. The left foot also revealed a plantar wart at the center of the heel and a hard, excruciatingly painful lesion at the outer border of the heel. This second lesion was a nodule of approximately 15 mm. diameter and reddish blue in appearance. The center of the lesion was soft and bleeding slightly, apparently as a result of the last desiccation treatment. A sterile dressing was applied to the large lesion and an appointment for surgery made. Laboratory findings were all within normal limits.

Anesthesia was obtained with 6 cc. of Xylocaine®[1] 2% with epinephrine 1:100,000. Two semi-elliptical incisions completely surrounding the tumor were made. The tumor, extending into the subcutaneous tissue, was removed by both blunt and sharp dissection. Because of the size of the tumor, much fat was removed and the apexes of the incision were lengthened longitudinally in order to effect closure with 3 vertical mattress and 5 interrupted sutures of #000 silk. Telfa®[2], a dry sterile dressing, and a compression bandage of 3-inch elastic adhesive were applied to complete the dressing.

Postoperative medication consisted of Darvon Compound®[3], two capsules every five hours, and elevation of the leg. All sutures were removed in eight days and complete healing required six weeks.

Pathologist's report: Macroscopic Description—specimen consists of an irregular segment of tissue measuring roughly 15x7x4 mm.

®[1] Astra ®[2] Curity ®[3] Eli Lilly

Microscopic Description—sections disclose glomus tumor consisting of fat and fibrous stroma containing nerve bundles and small vascular channels. No conclusive evidence of malignant neoplasia observed in the sections submitted.

Diagnosis: Glomus Tumor.

This case report illustrates the need for an adequate pathology report and shows that more than one type of lesion can occur on the same foot at the same time and will mask the proper diagnosis. Fortunately, in this case, the tumor was not malignant. The late surgical intervention, due to the masked diagnosis, could have had serious consequences.

The verrucae were treated with conventional chemical cautery and were completely resolved by the time complete healing of the wound occurred.

*1055 Blake Ave.*

## BOOK REVIEWS

### WALK AND BE HAPPY

A Specialist's Guide to Healthy Feet by Benjamin Kauth, Pod.D., S—, 126 pps. illustrated. Published by The John Day Company, New York, 1960. With an introduction by Gilbert Hollander, Executive Secretary of the Podiatry Society of the State of New York.

*Editor's Note: This book can have much importance in over-all public education and information programs in the profession, especially as to the public's image of the podiatrist (chiropodist) and his medical function. This is the first time a major publisher has issued a book of this kind and it should earn, deservedly, a place on the family shelf of health books. Because it can benefit the profession by highlighting the foot specialist and his role in the medical world, we call it to your attention by asking Dr. Marvin Shapiro, our immediate past president, to review "Walk and Be Happy."*

One of the most vexatious elements of our day-to-day relations with our patients is the language barrier which separates layman and professional and frustrates our attempts to explain the many diseases of the human foot and their meaning for the patient. If the explanation is oversimplified, there is always the danger that the patient will hobble off, convinced that there's "nothing to be concerned about." If the explanation becomes a medical dissertation in depth, we frequently frighten the patient and his natural hypochondriacal bent leads to endless requests for additional, unnecessary consultations.

A new, slim volume has just appeared which should prove valuable in breaching this communications barrier. In an airy, anecdotal literary style, Dr. Benjamin Kauth has compressed the compendium of foot ills into an easily swallowed, easily digested prescription. Avoiding the pitfalls which befall so many books by medical men, he freshens his ever-ready prose with a witty phrase, a pithy story.

For example, after he reports that eight of every ten Americans polled by the Gallup organization complained that their feet hurt, Dr. Kauth remarks that the plaint "my feet are killing me" has become the national wail. Then, tongue in cheek, he records that no podiatrist has ever been known to sign a death certificate.

It is this kind of treatment which will hold the lay reader's attention long enough to get its health message across. Although authoring potential best sellers is a new kick for Dr. Kauth, he's really an old hand at writing. For 15 years he was director of public relations for the Podiatry Society of New York State and, more recently, has

been a consultant to various firms, government agencies, educational institutions and a variety of communications media in the field of foot care and foot health.

The volume carries an excellent introduction by Gilbert Hollander, Executive Secretary of the Podiatry Society. Heeding the injunction that one picture is worth as much as 1,000 words, Dr. Kauth has filled his 126-page volume with a series of thumbnail sketches which are in keeping with the light tone of the book.

In a section which specifically discusses the various ailments of the feet, Dr. Kauth clearly delineates the areas of trouble which can be handled by the intelligent layman and the conditions and diseases which require the attention of the professional practitioner. He stresses the need for caution and decries "bathroom surgery." A special chapter is devoted to the pedal problems of the senior citizen and the diabetic. Additionally, there are sections on the development of the foot from infancy through adolescence, the foot foibles of the American woman, the working and walking burden of masculine feet.

In a special do-it-yourself chapter, Dr. Kauth guides the shoe buyer through the process of selecting a comfortable and healthy shoe wardrobe. In another, he suggests foot and leg exercises for young and old, including games which can be played with babies and young children for whom exercises have been prescribed. In a third chapter he reports on and evaluates the variety of molded shoes available. For the historical minded, he has included an amusing chapter on the history of footwear with an explanation of the roots of some of our present footwear fashions, the sane as well as the ridiculous.

Throughout the book, wherever pertinent, Dr. Kauth quotes authorities in the profession and underscores the fact that the podiatrist is the specialist in matters of foot care. A final chapter deals with the role of organized podiatry in setting up a foot health program and calls for support.

The first edition of 5,000 copies of "Walk and Be Happy" has already been placed in school and public libraries throughout the United States. A copy belongs in every podiatrist's waiting room and in the hands of every man or woman who has at any time been concerned with the care of his feet.

*Marvin W. Shapiro, D.S.C.*

## FRACTURES AND ORTHOPAEDIC SURGERY FOR NURSES AND PHYSIOTHERAPISTS

Arthur Naylor, Ch.M., M.B., M.Sc., F.R.C.S., Fourth Edition, Cloth $6.50, Pp. 358 with 276 illustrations, E. & S. Livingstone LTD., Edinburgh and London, "The Williams & Wilkins Co., Baltimore, exclusive U. S. agents."

In this new edition the author has expanded the sections dealing with shock, hand and nerve injuries. The book has been written to guide the nurses and physiotherapists who care for traumatic and orthopedic cases.

It is divided into 14 chapters devoted to Fractures & Dislocations; Diseases of Bone & Joints; Affections of the Soft Tissues; Epiphyses; Peripheral Vascular Lesions; Affections of the Spine; Affections of the Foot.

Although the bulk of material is well known, the simplicity of presentation makes it worthwhile reading. The chapter in relation to Affections of the Foot covers only 24 pages with rather sketchy information. Some readers may feel that further details and treatment would be desirable. Apparently these are minor flaws in an otherwise excellent book and it would be a welcome addition to the doctor's library.

*Robert Shor, D.S.C.*

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A. RUBIN, D.S.C., Editor

*Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.*

## THE PRESIDENT SPEAKS OUT

One of the greatest problems of our profession today is not inability to gain recognition—this for the most part has been accomplished; it is not our inability to supply adequate public information—this is being done; it is not our inability to be recognized by allied health interests—this is being accomplished; it is not our inability on a National level to have hospital privileges without the loss of accreditation to the hospital—this has been accomplished. What remains in this regard is careful approach to each individual hospital where we desire to offer our services for the betterment of public foot-health.

Our greatest problem is ourselves. It is the actions of a few members who have become self-indulgent and selfish, who take advantage of the privileges of our profession and make excessive fee charges for certain techniques, thrusting upon the insurance industry, expecting insurance officials to accept their insurance forms, carte blanche, with no questions asked. This borders on downright dishonesty which endangers the rights and privileges of every practitioner who has a sense of moral obligation, and lives up to a code of ethics. This has caused insurance companies to re-evaluate the claims of podiatrists and, in fact, deny many, to the detriment of the patient as well as the practitioner.

Another problem is the fact that some have lost sight of the boundaries of the field of podiatry, defined by the various state laws which regulate their practice and have lost track of the fact that there is still much more to be learned about the foot which is by public mandate our area of concern.

Let us see to it that we confine ourselves to our specific field and not try to practice medicine as frustrated general physicians. All branches of the healing arts have seen fit to police themselves in an effort to control and eradicate such sore spots, within their own profession. Why not Podiatry? It seems to me that the time has come when we must set up our own policing agency, nationally and on a state level, immediately, lest someone else outside our profession finds it necessary to do so. Let's take the foot for which we are responsible and do the very best for it. We have the ability and the initiative. There is great work yet to be done.

MARVIN D. MARR, D.S.C.

Guest Editorial:

## WHAT MAKES A PROFESSION?

A profession is variously defined as a vocation requiring knowledge of some department of learning or science which demands special education. This general description is only a shell which is so flexible and has so many facets and variables that it hardly paints a true picture.

Let us take a look at the medical profession and its allied branches. What is involved besides education, bedside manner, doctor-patient relationship, moral obligations, financial considerations, community relations, organizational activity and others.

The most important single factor, however, is the establishment of a good professional image in the mind of the patient. We are bound to associate places and people with atmosphere. An impression of some kind is always imprinted after a major event like a visit to the doctor's office. For a child, it sometimes means a lollipop. For the adult, it could be an image of a warm and interested relationship or an impersonal contact which the practitioner evaluates chiefly in dollars.

We would all like to achieve the proper image, the key to word of mouth advertising. This, in turn, is the best and most lasting. People are still people. The fast brush-off or the quick injection was never conducive to good professional relations. We hear time and again that, "I went to Dr. So-and-So and he didn't even take my pressure," or "He didn't even give me a prescription." Old people require just a bit more attention. Sometimes they just want someone to talk to, even if there is nothing organically wrong. Everyone has troubles. The old folks with fixed incomes are in a growing group that has plenty of them. Just a little extra consideration with a friendly ear and discretion as to fee can go a long way toward good professional relations.

A doctor, when asked if a patient was in condition to make a trip, wisecracked, "You can get killed crossing a street right here in town." Another told a patient that she was just getting old; she reminded him of his mother-in-law. Both remarks were obvious, but in poor taste. Both patients changed doctors.

It is that little extra something that shouldn't be overlooked no matter how busy the office. It is possible to create an image of speed and efficiency with kindness. It is also possible to create one of speed, inconsideration, bluntness and mercenary motives. Whichever image you achieve is yours for the making, but rest assured that the better takes a lot less effort to maintain than the effort involved in rebuilding one (and an image can be damaged beyond repair). When dealing with people, they should be treated as individuals. For the most part, they will react according to their treatment.

The true practitioner of the healing arts will not envision a dollar sign on the face of a patient. He will soon find, however, that dollars and patients both will find their way to his door, if he but pauses once in a while for a critical inventory of his real service in the struggle to alleviate human suffering.

*Philip Saginor, F.A.C.A.*
*Professor of Pharmacology*
*Ohio College of Chiropody*

## TAX CLINIC

HENRY KENT, C.P.A.
New York, N. Y.

*Mr. Kent will conduct a regular column on tax problems for the podiatrist-chiropodist. Your questions may provide the basis for future columns.*

### CAN LIVING EXPENSES BE DEDUCTED AS MEDICAL EXPENSES?

Among the so-called itemized deductions on the individual income tax return, the medical expense deduction is one that sometimes poses a problem to taxpayers. The common deductible medical expenses are for doctor and dental bills, expenditures for chiropodists, chiropractors, nursing and hospital care, drugs and medications, ambulance services, certain transportation expenses to obtain medical aid and amounts paid for health and accident insurance. Funeral expenses are not deductible medical expenses. The term "medical care" is broadly defined to include amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease. Of course, the deduction is limited to the extent that the taxpayer must absorb the medical expenses up to 3% of his adjusted gross income (for medical care) and an additional 1% for amounts spent for drugs and medications.

This article will confine itself, however, to an additional problem in connection with the income tax deductibility of medical expenses. There is still no definite answer to the question of whether a taxpayer, who is required by his doctor to take a trip for medical reasons, can deduct the costs of his living expenses while away from home.

Two Tax Court decisions, which approached the problem from different angles, are still in a state of flux. The latest action by the Tax Court was its decision in the "Carasso Case." The "Carasso Case" involved a taxpayer who lived in Brooklyn, New York. He suffered a serious illness, which required major surgery. His recovery was slow and upon the recommendation of his doctor, he went to Bermuda for further convalescence. On his tax return, the taxpayer claimed deductions not only for transportation to Bermuda for his wife and himself but also the amounts spent for a hotel room and meals. The Tax Court, saying that such trips to resort areas must be closely scrutinized, found the taxpayer made the trip solely for medical reasons and that the presence of his wife was indispensable. Hence, the transportation expense was deductible. On the other hand, the decision held that the living expenses while in Bermuda—the hotel and meals—were not deductible. The court looked into the legislative history of the Code section dealing with medical deductions (Sec. 213). The wording of that section raises the inference that deductions incurred on such trips are limited to transportation expenses only and ordinary living expenses are not deductible. In fact, this is the expressed intention of the congressional committee reports in the comments on this section.

Eight months before this decision, the Tax Court decided another case involving similar circumstances and came up with a different answer. This case was the "Bilder" case. The facts in the "Bilder" case were these:

The taxpayer was a known sufferer of arteriosclerosis, a heart disease in which muscular tissue of the heart atrophies because of a lack of sufficient blood circulation. Because a patient's susceptibility to attack increases during cold weather, the taxpayer (a New Jersey attorney) would have been advised to spend the winter

months indoors or hospitalized; but, because he was a hyperkinetic person with an unusual inner stress and tension, such advice would have resulted in danger to health from two sources. Extended inactivity would have intensified the inner stress and tension and the emotional upset would tend to cause the recurrence of heart attacks. An eminent heart specialist, therefore, advised Mr. Bilder to spend the winter in a warm climate where he might partake of mild exercise. In addition to the prescription of warm weather, the taxpayer was advised to take Dicumerol, an anticoagulant, which has to be administered by a competent doctor. Mr. Bilder for two years spent four winter months each year in Fort Lauderdale, Florida, choosing that site because of the climate and because a doctor experienced in the administration of Dicumerol practiced there.

Both the travel expenses between New Jersey and Florida and the living expenses of the taxpayer and his family (wife and daughter) were claimed as deductible expenses for medical care. The Tax Court permitted the taxpayer to deduct his own travel and living expenses but not those attributable to his family.

The court stated "the record clearly supports a conclusion that the primary and only purpose for the housing and transportation expenses of the taxpayer here involved which were incurred by him was that he might so conduct his life after four heart attacks, with their resulting myocardial infarctions, that he could develop sufficient additional blood vessel capacity to properly nourish and keep functioning such remaining heart muscle tissue as he still possessed while, at the same time, be located near medical facilities to supervise and administer the drug, Dicumerol."

The decision stated four criteria for the deductibility of expenses connected with medical care:

1. What was the purpose of the expenditure sought to be taken as a medical expense deduction?
2. Would the expense have been incurred but for the advice of a physician?
3. Did the expenditure have direct relationship to the treatment of a specific disease?
4. Was the treatment reasonably designed to effect diagnosis, cure, mitigation or prevention of a specific disease?

In applying the four tests, the Tax Court allowed the deduction for the taxpayer's expenses only.

This was the first case, under the 1954 Code, in which living expenses have been allowed as a part of medical care when they were not part of a hospital bill. For that reason alone, the Bilder case is significant. The Internal Revenue can be expected not to follow the case in so far as living expenses are concerned. The case has now been appealed to the U. S. Court of Appeals for the Third Circuit. In the meantime, it is perhaps an excellent idea for taxpayers in a similar situation as Bilder or Carasso to claim deductions on their tax returns for such medically related expenses incurred by them in order to protect their rights in case the different decisions are finally adjudicated by the highest Court in the taxpayers' favor. A final answer to this question, however, will only come in time, and any deduction taken now will probably be challenged by the Internal Revenue Service, subject to the decision of the Court.

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"The measure of success is not whether you have a tough problem to deal with, but whether it's the same problem you had last year."

*General Electric News*

# PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

*A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.*

## Triurate

**Description:** Each Triurate tablet contains: Flexin (Zoxazolamine) 100 mg., Colchicine (0.5 mg.) 0.5 mg., Tylenol (Acetaminophen) .300 mg.

**Action and Uses:** Triurate provides comprehensive therapy in the management of chronic gout and gouty arthritis. Two specific anti-gout agents are present: Flexin, a potent uricosuric compound, which markedly increases urine uric acid excretion and thereby reduces serum uric acid levels and Colchicine, in a dose (1/120 grain) found most useful for preventing flare-ups of acute gout. Tylenol supplies effective analgesia for the chronic aching and discomfort present in many patients with gout.

**Indications:** Triurate is indicated in chronic gout and gouty arthritis, especially for the reduction of serum uric acid levels and for the prevention of flare-ups of acute gout. It is very useful when aches, pains and general discomfort accompany chronic gout or gouty arthritis.

**Advantages:** Triurate combines three valuable ingredients in one dose: (1) A potent uricosuric agent, Flexin for the removal of excess amounts of uric acid from the body, aiding in the disappearance of tophi, decreasing the frequency of acute attacks of gout and the marked reduction in chronic joint pains between acute attacks. (2) The time-tested agent colchicine, specific for the control of gout. (3) An effective, non-irritating analgesic, Tylenol, for the relief of the aching discomfort which commonly accompanies chronic gout and gouty arthritis. Unlike the salicylates Tylenol does not interfere with the action of uricosuric compounds. Triurate therefore provides overall management of chronic gout and gouty arthritis.

**Administration and Dosage:** Average dose, one tablet three (3) times a day after meals. Care should be taken to maintain an adequate urine output to prevent the precipitation of urate calculi. The patient should be instructed to ingest two full glasses of liquids with each meal and two full glasses of liquids between meals. If possible, serum uric acid should be measured at regular intervals. When the level is stabilized at the lowest attainable in the individual patient (in approximately two months), dosage may be reduced to two tablets daily and this dose maintained as long as serum levels (uric acid) remain low.

**Relation to Acute Gout:** While in the average patient with chronic gout the colchicine in Triurate should prevent a flare-up of acute gout, in patients with a history of frequent or severe attacks, colchicine alone should be given prophylactically for a few days before starting Triurate to avoid such an exacerbation which is possible when any potent uricosuric drug is first administered.

As with other uricosuric agents, Triurate is not recommended for treatment of acute gout. Colchicine alone or other agents in appropriate doses are required to control this stage of the disease. When the acute inflammation subsides, Triurate should be started to maintain lowered serum uric acid levels and prevent subsequent attacks.

**Side Effects:** Triurate seldom produces side effects of any significance. Occasionally a patient may notice nausea, dizziness, drowsiness, urticaria or other type of allergic skin eruptions. Diarrhea may occur in

some patients. In isolated cases or instances, hypersensitivity reactions may be due to Flexin, some instances of this type have been reported but rather rarely. If acute abdominal pain or flank pain, skin rash or jaundice should develop, Triurate should be discontinued. The onset of acute pain or rather acute flank pain may indicate development of urate calculi rather than renal irritation per se.

**Supply:** Bottles of 50 tablets. Each tablet is scored, beige colored and imprinted "McNeil." By McNeil Laboratories, Inc., Philadelphia 32, Pa.

### Neo-Mantle ™

**Description:** Creme or lotion containing neomycin sulfate 5.0 mg./Gm. (equivalent to neomycin base 3.5 mg./Gm.) in the exclusive Acid Mantle® vehicle.

**Indications:** Topical treatment of cutaneous pyodermas including impetigo contagiosa and other pustular dermatoses, ulcerative impetigo, superficial folliculitis, sycosis barbae, furuncles (with adequate drainage).

**Directions:** Remove crusts gently after soaking in hot Domeboro Solution for an hour. Bathe and pat dry. Then apply Neo-Mantle Creme or Lotion twice a day to affected area. Not to be used in deep or puncture wounds, serious burns or infections. Discontinue use if redness, irritation, swelling or pain persist. Do not use in eyes.

**Supply:** Creme in ½ oz. tubes. By Dome Chemicals Inc., 125 West End Ave., New York 23, N. Y.

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## George D. Scherer
### Memphis, Tenn.

Dr. George D. Scherer of Memphis, Tennessee, passed away on May 29, 1960, at the age of 84 years. Dr. Scherer practiced originally in his father's office who was his preceptor. His father, Charles J. Scherer, 1846-1915, was probably the South's first chiropodist, receiving his training in Philadelphia following the Civil War, where he served in the Union Army. Charles J. Scherer opened a chiropody office in Memphis in 1870. George D.'s mother was Victoria Davis Scherer. His brother, Karl Scherer, who died in 1946, was also a chiropodist.

George D. Scherer augmented his preceptor training under his father by attending the New York Chiropody School, graduating with the M.Cp. degree in 1916. A charter member of the Tennessee Chiropody Association, he received honorary Doctor of Surgical Chiropody degrees from Illinois College, Chicago College and the Ohio College.

He represented the state of Tennessee in the House of Delegates for more than 10 years. He was chairman of the Regional Planning Committee under the late Secretary Stickel for 13 years. The 1952 annual meeting in Memphis was named in his honor. The 1960 House of Delegates posthumously elected Dr. Scherer a Past President Emeritus. Other honors bestowed on Dr. Scherer were: Honorary Member of Alabama and of the South West Chiropody Congress and the states of that region; Life Member of the Memphis and Tennessee Associations; Life Member of the National Association; received Temple University Distinguished Service Award in 1952; Life Member of Alpha Gamma Kappa Fraternity. He had many personal awards, his two most cherished being his Chair, presented him by the "Dixie" zone, 1952, and the Gold Watch presented to him by the South West Chiropody Congress in 1953.

Dr. Scherer was a member of the Masonic Fraternity and the Al Chymia Temple, A.A.O.N.M.S.

He is survived by a daughter, Roberta G. Scherer of Memphis, a son, Charles H. Scherer, D.S.C., of Chattanooga, Tennessee, and a sister, Mrs. Kate S. Jones.

## DIGESTS FROM THE LITERATURE

*Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.*

### ANESTHESIA

*The Analgesic Properties of Anileridine, Meperidine and Morphine: A Comparative Study*, Gordon, R. A., and Linderville, C. W. P. Canad. Anesth. Soc. J. 7: 32-38, January 1960.

When a comparative study of the analgesic effects of these three agents in relieving postoperative pain was made, it became evident that all three produced analgesia satisfactorily, when given in proper doses, without producing any significant change in cardiovascular or respiratory function. Their respective potency had been determined earlier, and the doses administered were: anileridine 25 mg. per cc.; meperidine 50 mg. per cc.; morphine 5 mg. per cc. Of the 1,117 patients studied (ages were from 15 to 86 years), 382 received anileridine, 389 meperidine, 346 morphine. The relative potency of these drugs is shown by the average dose received by these patients; anileridine 38.8 mg., meperidine 73.6 mg.; morphine 8 mg. More "good" and "fair" effects were recorded for anileridine and meperidine than for morphine. The calculation that 40 mg. of anileridine is equivalent to 100 mg. of meperidine in analgesic potency appeared to be correct, but no accurate calculation was made. But that 10 mg. of morphine is equivalent to 100 mg. of meperidine did not seem accurate; meperidine appeared to be somewhat more potent in comparison with morphine.

No significant difference between the three drugs in regard to duration of the sedative action. Some patients required no further sedation after leaving the recovery room; 43 of this group had received anileridine, 39 meperidine, 48 morphine. Changes noted in blood pressure and pulse rate were not consistent. Blood pressure in two patients remained within normal limits; in the others it either increased or decreased by 10 mm. of mercury systolic. In only two patients was the decline in blood pressure of any concern. Both had received meperidine, but in both pressure responded to treatment. Circulatory depression occurred in none of the patients given anileridine or morphine. When changes in blood pressure were considered in relation to the operative site, a decided tendency was noted for pressure to rise after use of analgesics in patients who had abdominal operations, and a tendency to fall from above normal to normal levels in other patients. This seemed to indicate that the original pressure levels are influenced by pain stimuli, and that the pressure tends to return toward the patient's normal level after relief of pain.

Depression of respiration was a common reaction to all of these drugs. Almost always where respiration was decreased, this decrease represented a change from a faster than normal respiratory rate to a more normal range. Marked respiratory depression did not occur in any patient in this series. Thus, all three drugs produced satisfactory analgesia — with anileridine (Leritine) the most satisfactory, for relief of postoperative pain.

### CIRCULATORY SYSTEM

*Vasomotor Peculiarities in Connection with Age*, Lupu, N. G. Papazian, R., and Iota, C. Rumanian Med. Rev. 3: 76-77, 1959.

A study was made of vasomotor abnormalities in 163 individuals in two groups:

the old, aged 51 to 70 years and young-old, aged 19 to 45. Each group contained apparently normal controls. Studies were made of the peripheral aspects of vasomotricity (reactions of vessels of the skin to pharmacodynamic stimuli), and of its central regulation (by use of thermometry during vasodilation and vasoconstriction). The results seemed to indicate:

1. Normal, aged individuals with normal blood pressure show hyporeactivity of peripheral vessels in comparison with normal young persons with normal blood pressure.

2. This hyporeactivity differs according to the stimuli used—in decreasing order as follows: mechanical stimuli, histamine, dionine, and adrenalin. In the aged, histamine reactions are delayed and less intense, but last longer than in the younger controls.

3. With existence of various diseases, there is a specific reduction of the differences between young and aged: (a) Both age groups in the presence of hypertensive disease show hyperreactivity of the peripheral vessels to mechanical stimuli and to adrenalin; (b) the aged have a decreased ability in central control of peripheral vessels; however, this is compatible with balanced living conditions.

The conclusions are that the aging process provides a series of beneficial, along with untoward, effects as regards the general economy of the body. First, some degree of protection is provided by a general hypoactivity against the onset and course of diseases indicating major vasomotor disorders. Second, the lesser decrease in reactivity to adrenalin as compared with other stimuli and the decreased ability in vasomotor control seem to enhance elements for onset of diseases of the pressor type. Third, because of the long duration of reactions produced by histamine, though of low intensity, a problem arises as to whether onset of vascular sclerosis may not also be promoted by a histaminic mechanism.

## NEW GROWTHS

*Connective Tissue Nevi: Familial Occurrence and Association with Osteopoiklosis,* Smith, A. D., and Waisman, M. Arch. Derm. 81: 249-52, 1960.

The etiology or pathogenesis of connective tissue nevi, a rare lesion, is unknown. Three cases occurring in one family, two of whom had skeletal disturbances characteristic of osteopoiklosis, are described. They were observed in a boy of six years, his sister 4 years old, and his father aged 31 years. No other cases were known to exist in relatives of the parents. Two other children and the mother were normal.

Except for cutaneous and osseous malformations, involvement of other tissues or organs was not apparent. The lesions, from pinhead size to 1/2 cm. or more in diameter, were smooth, white or yellow, flat or slightly elevated, and somewhat indurated. The lesions were grouped together to form patches, usually localized asymmetrically. Large areas may be involved in some cases. The boy had a patch first on the chest at the age of 3 years; this increased while other lesions formed over the upper abdomen, midchest, and small of the back. The father had a lesion on the right hip as long as he could remember. The daughter had a plaque on the posterior aspect of the left thigh since the age of two years.

The usual locations affected are the carpal bones, tarsal bones, phalanges, epiphyses and metaphyses of the long bones, and the pelvis. Less often the spinal column, ribs, sternum, and (rarely) the skull, are involved. The abnormality develops over a period of years until about puberty, when no further osseous changes take place. The foci of compact bone is found microscopically to consist of a close-meshed network of osseous trabeculae.

## ORGANIZATION NEWS

*Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.*

### FLORIDA

The semi-annual meeting of the Florida Podiatry Association was held in Tampa, Florida, at the Hillsboro Hotel on October 20-22, 1960. Dr. Herbert Lewy of the Central Florida Podiatry Group served as convention chairman, along with Drs. Irwin Feinman, Joy Adams, W. E. Ellison, Raymond T. Burton and Schofield Lewy. Featured speaker on the scientific program was Dr. Herbert Levin of Norristown, Pennsylvania. His subject was "The Complete Cycle of Chiropodical Surgery." Dr. Seward Nyman attended the business meeting sessions, representing the American Podiatry Association.

Dr. John McCaffery, President of the Florida Podiatry Association, presided over the meetings and Dr. Edward Hurd, delegate to the national convention, made his annual report. Leo Wachtel, M.D., President of the Florida Medical Association, and George Karelas, M.D., Chairman of the Governor's subcommittee on Health Care of the Aged, were voted certificates of merit by the society.

### IDAHO

Sun Valley, Idaho, was the scene of the most successful podiatry conclave ever held in the great Northwest. Over 60 D.S.C.'s from 15 states heard such outstanding speakers as our own President-elect (now President) Marvin D. Marr of Cedar Rapids, Iowa, tell of the great advances and workings of our national organization and its officers and ask cooperation on local levels to help our national officers achieve success for all members. Raymond K. Locke presented his plaster casting treatment of metatarsus valgus and varus in early childhood and discussed new injectable drugs in


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| 9:30 | Theo Martin | Trophic ulcer ✓ |
| 10:00 | Raymond Butler | Fit corrective brace |
| 10:30 | Harriet Nelson | Inflamed nail grooves ✓ |
| 11:00 | Elmer Spoff | Shoe dermatitis ✓ |
| 11:30 | Ed Dunn | Callus ✓ |
| 12:00 | P.M. | |
| 1:30 | James Taylor | [illegible]dema ✓ |
| 2:00 | Allen Jackson | Ro[illegible] examination |
| 2:30 | Edith Ramont | Varic[illegible]er ✓ |
| 3:00 | Rita Wilbourne | Stasis [illegible]is ✓ |
| 3:30 | Jess Sweem | [illegible]ergic e[illegible] |
| 4:00 | Myrtl[illegible] | [illegible]p care ✓ |
| 4:30 | | |
| 5:00 | | |
| 5:[illegible] | | |
| 6:[illegible] | | |
| 7:00 | | |
| 7:30 | | |
| 8:00 | Filip[illegible] | |
| 8:30 | Carol Johnson | Infection(secondary) ✓ |

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the treatment of foot disabilities. Alec C. Levin presented his studies of surgical management of specific foot disabilities and an informal dissertation on professional relationships and office management. Phillip Gardner explained the use of negative galvanic current in the surgical correction of the onychocryptic nail and of the success of the California Podiatry Hospital. Arthur Cudmore, D.O., spoke on the pronation syndrome and its effect on the superstructure, plus modern concepts of cardiovascular diseases as related to postural fascial imbalances. George Custer fascinated his audience with his clinical hypnosis, its practical application and techniques in a podiatry office.

Henri L. DuVries, now of Oakland, California, lectured on common surgical foot problems, diagnoses and judgments necessary for proper presurgical procedures as well as actual surgical procedure and technique and postoperative care.

Ladies' programs and social activities rounded out a complete program.

## IOWA

Vaughn E. Wicks of Mason City has assumed the state chairmanship of the fund drive to support the education of future chiropodists-podiatrists. He heads the Iowa effort for the Alumni Education Foundation of the Illinois College of Chiropody and Foot Surgery.

## MICHIGAN

Drs. William Wagner and Don Borchard recently discussed foot and ankle injuries with athletic coaches from throughout the state at the annual coaching clinic sponsored by Michigan High School Coaches Association, held at Central Michigan University.

Program outlines for local action in changing the Association's name from "chiropody" to "podiatry" have been distributed to all division officers. Extra copies have been included so that representatives in each community will have them available.

The annual meeting of the Michigan State Podiatry Association was held the weekend of October 29-30. Scientific program was highlighted by Drs. Maurice Sherman, Irving Sward and Herman G. Miller of the Chicago College of Chiropody.

Virginia Heeringa has been added to Mr. Fitzke's M.S.P.A. staff.

## MINNESOTA

A three-day annual meeting of the Minnesota Podiatry Association and the Minnesota Academy of Foot Surgeons (study group) was held again at Rutgers Pine Beach Resort in Brainerd, Minnesota. Dr. Clarence Aho was host; Drs. Keith Jorgensen and Edward Chrencik, program chairmen.

Dr. Ross Tennant, former practicing podiatrist, now with the Little Yankee Shoe Company, spoke to the M.P.A. members during their scientific session. Dr. Earl Kaplan of Detroit, Michigan, and Civic Hospital in Detroit, spoke to the surgery study group.

Dr. George Nelson, Minneapolis, a stalwart in the profession of podiatry in Minnesota and head of the national museum, was honored at the annual banquet by a special service plaque presentation from the entire state association.

New officers installed at the meeting are as follows: President, William Perendy of Mankato; President-elect, Ernest Ueland of Minneapolis; 1st Vice President, Robert Sabbann of Rochester; 2nd Vice President, Omer Welna of Moorhead; Secretary-Treasurer, Robert Ray of Minneapolis; Region 6 Delegate, Willard Olson of St. Paul; A.P.A. Delegate, Palmer Goulson of Minneapolis, and Alternate, Edward Tarara of Rochester.

## PENNSYLVANIA

### Northwestern Division

A dinner meeting was held at the David Mead Inn, Meadville, on Sunday, September 18, 1960, with 44 members and guests present. President Crawford opened the meeting by introducing the guests.


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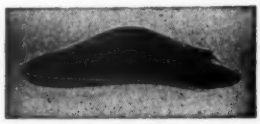

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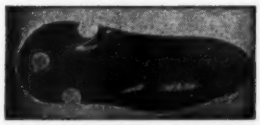

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Earl Curtis reported on activities of his Hospital Relations Committee and told the group of plans to establish more chiropodists on hospital staffs within our division.

Joseph Fletcher, President of the state society and A.P.A. Delegate, reported on state affairs and the recent national convention in Chicago. Leo Lacey, scientific chairman, introduced the scientific speaker, Ralph W. Dye, who presented an interesting and informative talk and demonstration on modern scientific diagnosis.

### Philadelphia College of Chiropody

The Pennsylvania Department of Public Instruction, Harrisburg, Pa., has advised the Chiropody Alumni of Temple University that "a provisional four-year charter has been granted to the new Philadelphia College of Chiropody." Plans are being made to admit a freshmen class in September 1961. More information will be forthcoming soon.

### FEDERATION OF CHIROPODY BOARDS

The Federation of Chiropody Boards held their 25th Annual Meeting at the Drake Hotel in Chicago, August 27, 1960. Officers were elected as follows: President-elect, A. G. Kalin of Detroit, Mich.; 1st Vice President, Francis Schwarz of Troy, N. Y.; 2nd Vice President, Julius Citron of Phoenix, Ariz.; 3rd Vice President, H. A. McAninch of Spartanburg, S. C., and Secretary-Treasurer, L. A. Hansen of Kansas City, Mo. M. K. Upshaw, Jr., Jackson, Miss., assumed the office of President, and Morris Haas, Albuquerque, N. Mex., is the retiring president.

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## A.P.A. CHARTERED EUROPEAN TRIP

This is of immediate interest to all American Podiatry Association members. The A.P.A. is pleased to announce the completion of arrangements for special charter flights to Europe for The International Congress of Podology, September 8-12, 1961, Paris, France.

**Brief Details of Our Program:** Leave Miami International Airport on August 30 (at the close of the A.P.A. Meeting in Miami Beach) by chartered BOAC Brittania jet-prop flight to London. We will spend 3 days in London and will include in our program official sessions with the chiropody associations of Great Britain. Leaving England we will visit Amsterdam, Cologne, Rudesheim, Frankfurt, Luxembourg and end our pre-Congress trip in Paris on the evening of September 7. We will remain in Paris September 8 through 12, taking part in the International Congress of Podology, as well as enjoying social functions with our French hosts. Beginning September 13, we have arranged, for those interested, a 7-day tour by air to Zurich, Rome and Nice. The return charter flight will depart from Paris to Idlewild Airport in New York City on September 19.

**Who May Participate:** All American Podiatry Association members and their immediate families residing in the same household are eligible.

**Costs:** The cost of the round-trip charter flight to Europe, departing from Miami and returning to Idlewild, will be approximately $292 per person. The optional land arrangements beginning on our arrival in London and ending with the conclusion of the Podology Meeting in Paris on September 12 will be $260 per person. The cost of the optional 7-day air excursion to Zurich, Rome and Nice is $260.70 per person.

**How and When to Obtain Reservations:** Reservations will be assigned to American Podiatry Association members in order of their receipt. Only reservations for members who definitely wish to participate in the International Congress of Podology in Paris will be accepted. Reservations should be sent in to our Program Chairman as soon as possible. Refund of deposits will be made to any participant cancelling his reservation more than 30 days prior to departure.

**Additional Information:** Inquiries for additional information concerning our European Program should be addressed to the European Program Chairman. A detailed description of all arrangements will be forwarded by return mail. Use blank below.

---

Dr. S. E. Nyman
European Program Chairman, A.P.A.
3301 16th Street, N. W.
Washington 10, D. C.

Please make reservations for me and those named below for the American Podiatry Association's European charter in connection with the International Congress of Podology.

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NAME _____ ADDRESS _____

## THE ACADEMY OF PODIATRY

The Academy of Podiatry, incorporated in New York in 1917, is the oldest independent organization in podiatry except for the National and the various state societies of podiatry. In 1962, the Academy of Podiatry will have celebrated its 45th anniversary.

Traditionally, the Academy of Podiatry divests itself and does not enter into the field of podiatry legislation, convention or politics. Its main concern is to render scientific knowledge to its members, aid in research, assist its members in preparing material for publication. It does, however, lend its prestige and its support to progressive legislation and scientific activity.

Any podiatrist who is a member of the American Podiatry Association may be recommended for associate membership by a member of the Academy of Podiatry. An admission scientific paper must accompany the application. An associate member, who has been in the Academy for a minimum of three years and has presented two or more scientific papers, may be advanced to active membership. Advancement to Fellow is based upon the following: three years as an active member; the presentation of seven scientific papers written by the candidate; a thesis; must have appeared on the lecture platform at least five times; a degree of Pod.D. or its equivalent; a consistent attendance record. One year shall elapse from the time the application is made before action is taken. All requirements as indicated above must be met at the time of the application for Fellow.

The Fellows of the Academy of Podiatry have the power vested in them to create Fellows of the Academy of Podiatry. Two-thirds vote of the Fellows, present and voting, shall constitute the election of a Fellow. All written material must be on white stationery, 8½ x 11 inches, double-spaced, typed.

Applications or information may be ob-


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tained by directing inquiries to the Secretary of the Academy of Podiatry, Dr. Louis Lewy, 285 Madison Avenue, New York 17, N. Y.

Rounding out the fall term as officers of the Academy are: Sidney Kaplan, President; Abel Gorfain, Vice President; Louis Lewy, Secretary-Treasurer. The members of the Board of Governors are Drs. Irving Berry, Benjamin Brody, Alexander Goldschmidt, Jerome Goldstein, Mario Miletti, William Reife, Milton Roven, Ralph Tassini and Milton Windt.

Benjamin Brody, Ph.G., Pod.D., F.A.C.F.O.,
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STATEMENT REQUIRED BY THE ACT OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946 (Title 39, United States Code, Section 233) SHOWING THE OWNERSHIP, MANAGEMENT, AND CIRCULATION OF Journal of the American Podiatry Association, published monthly at Boston, Massachusetts, for October 1, 1960.

1. The names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, American Podiatry Association, 3301 16th St., N. W., Washington 10, D. C.; Editor, A. Rubin, D.S.C., 3301 16th St. N. W., Washington 10, D. C.

2. The owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual member, must be given.) American Podiatry Association, 3301 16th St., N. W., Wash. 10, D. C.; Officers (No stock): Dr. Marvin D. Marr, President, 204 Paramount Bldg., Cedar Rapids, Iowa; Dr. A. Rubin, Secretary, 3301 16th St., N. W., Wash. 10, D. C.

3. The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

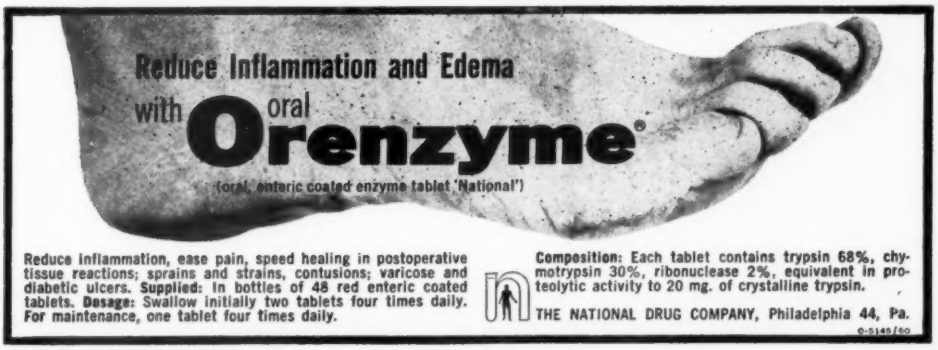
4. Paragraphs 2 and 3 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting; also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner.

5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: 5,376.

Signed A. Rubin, D.S.C., Editor

Sworn to and subscribed before me this 28th day of Sept., 1960.

A. S. McInnes. (My commission expires 10-31-62.)



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## FILM REVIEW: PODIATRY AS A CAREER

Since the statistics and some other information in the film, "Chiropody as a Career," were out of date, it was necessary to revise it. The title has been changed to "Podiatry as a Career." An explanation concerning this change is made at the beginning of the film before title and sound so that it may be shown or omitted as desired. The script is now narrated by a professional speaker and the term "foot specialist" is used on several occasions. The term "podiatry" is used throughout.

Certain parts of the surgery scenes which many people felt were too vivid have been omitted. The interview has been shortened but not the script. New charts are included covering entrance requirements, curriculum, college expense and other statistical information updated. Figure on net earnings has been changed to $12,000 and some new information has been included under "Opportunities." These changes have made it possible to reduce the length of the film for TV showings.

This film was very well received at the House of Delegates in Chicago, August 1960. Ask your delegate. The price, including reel, can and case, is $150, and it may be purchased from the Park Publishing House in Milwaukee, Wisconsin.

The monograph "Podiatry-Chiropody as a Career" has been revised too. Besides bringing all the information up to date, the term "foot specialist" is frequently used, the use of the terms podiatry and chiropody is explained, and the average net income of doctors who have practiced three years or more has been raised to $12,000.

This monograph is excellent both for student procurement and for public relations. Copies should be sent to all junior and senior high schools, also to junior colleges and to public libraries.

The price in quantities is as follows: 25 copies, $15.00; 50 copies, $25.00; 100 copies, $45.00; 500 copies, $210.00.


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Recently the editor of one of our very popular local newspaper columns celebrated his 20th Anniversary with the paper. Sketching his life for the past 20 years, he very casually mentioned that, among other things, one of his pet peeves was a corn on his little toe. Immediately we got busy. We wrote and told him that he need not suffer with his feet and that he should include a chiropodist-podiatrist in his family of doctors. We also enclosed pamphlets which we had obtained from our Washington office. Two days later, there appeared a lengthy paragraph in the "Rambler," his column. He told of the letter he had received from a Tulsa Podiatrist and then proceeded to make many quotes from the pamphlets we had sent, giving interesting facts regarding the feet. We were quite pleased to think such a small effort on our part had been given such wide publicity. But just a few days later, he again wrote about podiatry. This time he explained why "foot specialists" preferred to be called podiatrists. It is difficult to determine what those two items in the paper will mean in monetary returns, but it cost us about thirty minutes' time and a four cent stamp.

Our Public Relations Chairman, Mrs. Stanley V. Michota, 401 Victoria Place, Toledo 10, Ohio, has many excellent ideas and she in turn would like to learn of any of your activities.

*Mrs. Cleotha Parham, President*


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# *Dates to Remember*

## EVENTS

**Youth Fitness Week**
April 30-May 6, 1961. Sponsored by President's Council on Youth Fitness.

**Foot Health Week**
May 14-20, 1961. Sponsored by American Foot Health Foundation.

**Youth Foot Care Week**
Oct. 15-21, 1961. Sponsored by American Foot Health Foundation.

---

## MEETINGS

**American Podiatry Association**
Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

**Region One**
(Conn., Maine, Mass., N. H., R. I., Vt.)
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

**Region Two**
(New York)
New York, N. Y., Feb. 24-26, 1961
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

**Region Three**
(Del., Md., N. J., Pa.)
Atlantic City, N. J., Apr. 27-30, 1961
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

**Region Four**
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

**Region Five**
(Ill., Ind., Mich., Wis.)
Chicago, Ill., Mar. 17-19, 1961
Morrison Hotel
Dr. W. D. Canada, Pres.
1812 Nichol Ave.
Anderson, Ind.

**Region Six**
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood.
425 Kresge Bldg., Des Moines, Iowa

**Region Seven**
(Idaho, Mont., Ore., Wash., Wyo.)
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

**Region Eight**
(D. C., N. C., S. C., Va., W. Va.)
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

**Region Nine**
(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

**Region Ten**
(Ala., Ga., Ky., Miss., Tenn.)
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E.,
Atlanta, Ga.

**Region Eleven**
(Ark., La., N. Mex., Okla., Texas)
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

**Region Twelve**
(Ariz., Cal., Nev., Utah)
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

**International Union of Podology**
Second International Congress.
Belgium, France, W. Germany, Holland, Spain, Switzerland, Argentina, Sept. 8-12, 1961.

## MOOD ELEVATORS

**Contributions to this column are more than welcome. In fact it depends upon them.**
**A.O.P.**

Tinkles from the telephone

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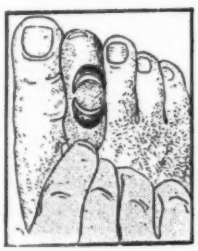

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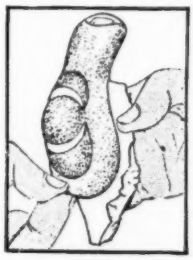

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# *Awards for Research Papers*

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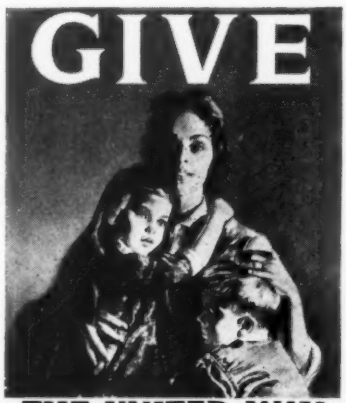


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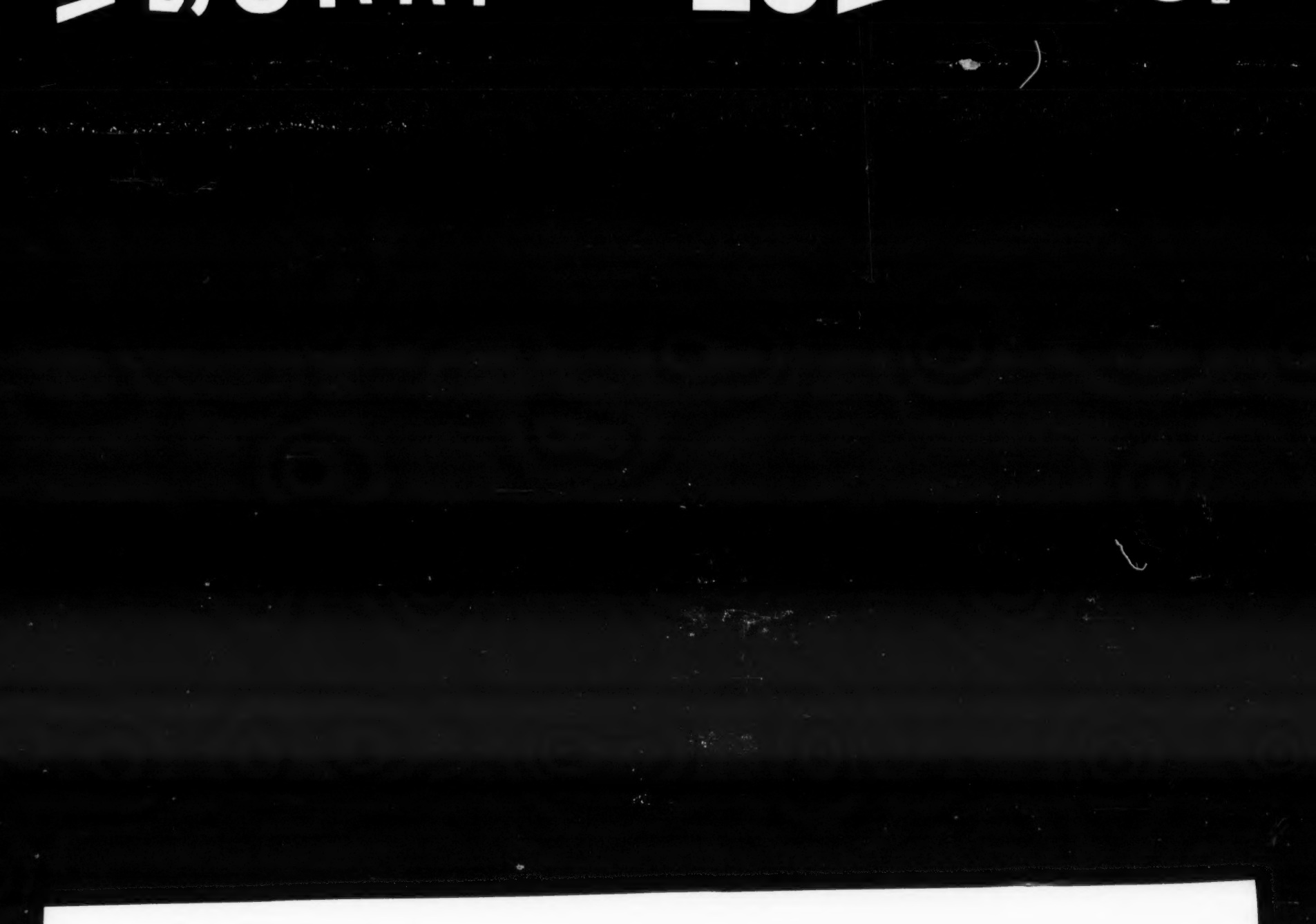
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